Oral health experiences of refugee children, and their parents' perspectives on access to oral health care

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Dedication

This thesis is dedicated to my grandfather

Late S. Karam Singh Saini

for his blessings and always believing in me.

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Contribution of authors

I, Manav Preet Singh Saini, am the student researcher and the primary author of all chapters. With the guidance of my supervisors, Dr. Mary Ellen Macdonald and Dr. Christophe Bedos, I designed this study. I completed the IRB process, recruited participants at the Montreal Children's Hospital, and led data generation and analysis with the guidance of my supervisors, and my thesis committee member, Dr. Beatriz Ferraz dos Santos. They also provided suggestions and constructive feedback during all the crucial steps for the study and provided edits and suggested revisions for all chapters. Mr. Martin Morris (McGill librarian) helped to design the literature review. Mr. Kevin Liu (undergraduate student) helped me with the Summary and Analysis coding approach.

Abstract

Note: The term ‘refugeed’ person is used in place of ‘refugees’ in this thesis. This term has been suggested by a community organization, Action Réfugiés Montréal, to signal the socio-political processes that force people to leave their homeland and transform them from citizens to ‘refugees.’ It is meant to signal the humanity of the individuals (1).

Background

Refugeed persons are people who have migrated to evade harsh conditions in their home country, such as environmental disasters, violence, and war. Although refugeed persons often resettle well in Canada, many still face numerous issues upon their arrival, including adapting to a new society, learning a new language, finding a job, and navigating the healthcare system of the host country. In Quebec, refugeed children experience a high prevalence of oral-related conditions. Nevertheless, research has not yet fully explored how they experience oral health and oral health care or how their parents experience accessing oral health care for them. Given this concerning scenario, the goal of this study was to shed more light on these issues to improve their access to oral health care.

Research Questions

How do refugeed children in Montreal understand oral health and experience oral health care, and how do refugeed parents experience accessing oral health care for their children?

Methods

We used a qualitative description methodology for our study. Participants included refugeed children aged 6–12 years and their parents. They were recruited from the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital (MCH), the only institution in Montreal that provides comprehensive free dental care for refugeed children. We conducted individual, semi-structured interviews with 11 children and 11 parents; the children and their parents were interviewed separately. Data generation and data analysis occurred concurrently. Data were analyzed using a thematic approach, including interview debriefing, transcript coding, data display, and interpretation.

Results

Our findings include five main themes: 1) The children's reflections on their mouths; 2) Experiences of children at the dental clinic; 3) Parents' understandings of oral health; 4) Experiences of parents prior to finding oral health care for their children; 5) Experiences of parents after finding oral health care for their children.

Refugeed children linked oral health to dental appearance (e.g., teeth color and alignment) and symptoms such as tooth pain and halitosis. They also associated oral health with preventive care, including diet, oral hygiene, and dental visits. When describing their experiences at the dental clinic, most responses were positive, and the children stated they were willing to visit the dentist again. However, discomfort during dental treatment and fear of pain during dental procedures made some children apprehensive of follow-up visits.

The parent participants understood and valued the importance of oral health, albeit they lacked knowledge about oral health coverage and information regarding

institutions that provide care tailored for refugeed persons. The parents also reported facing barriers related to transportation, limited dental coverage, and language, although they also expressed their satisfaction with the services provided at the Immigrant and Refugee Dental Clinic at the Montreal Children's Hospital. This satisfaction was associated with its cleanliness, the quality of the equipment, short waiting times on the day of the appointment, and the staff's understanding and polite behavior.

Conclusion

Our findings are useful for oral health care providers and institutions involved with refugeed persons. When informed about the challenges experienced, as well as the positive experiences of, refugeed persons, oral health care providers and institutions will be better placed to improve access for them. Moreover, our findings can help alert government and community bodies about the importance of better informing and guiding refugeed persons to access dental services. Further research should focus on the perceptions of oral health care providers involved with refugeed children in order to understand their experiences and their suggestions for improving access and oral health care.

Résumé

Remarque : Le terme « personne réfugiée » est utilisé à la place de « réfugiés » dans cette thèse. Ce terme a été suggéré par un organisme communautaire, Action Réfugiés Montréal, pour signaler les processus sociopolitiques qui forcent les gens à quitter leur patrie et les transforment de citoyens en « réfugiés ». Il vise à souligner l'humanité des individus (1).

Introduction

Les personnes réfugiées sont des personnes qui ont migré pour échapper aux conditions difficiles dans leur pays d'origine, telles que la violence et la guerre. Bien que celles-ci s'installent souvent bien au Canada, beaucoup sont confrontées à de nombreux problèmes, notamment l'apprentissage de la langue et la navigation dans le système de santé. Au Québec, les enfants réfugiés connaissent une forte prévalence de problèmes buccodentaires. Néanmoins, les recherches n'ont pas pleinement exploré comment ces enfants et leurs parents perçoivent la santé et les soins buccodentaires. Compte tenu de cette situation préoccupante, notre objectif était de clarifier ces questions afin d'améliorer leur accès aux soins buccodentaires.

Questions de recherche

Comment les enfants réfugiés à Montréal comprennent-ils la santé buccodentaire et vivent-ils les soins buccodentaires, et comment leurs parents vivent-ils l'accès aux soins buccodentairespour leurs enfants?

Méthodes

Nous avons utilisé une méthodologie de description qualitative. Les participants comprenaient des enfants réfugiés âgés de 6 à 12 ans et leurs parents. Ils ont été recrutés à la Clinique dentaire pédiatrique immigrante et réfugiée de l'Hôpital de Montréal pour enfants, la seule institution à Montréal qui offre des soins dentaires complets et gratuits aux enfants réfugiés. Nous avons mené des entretiens individuels semi-structurés avec 11 enfants et 11 parents, les enfants et leurs parents ayant été interrogés séparément. La production et l'analyse des données ont eu lieu simultanément. Les données ont été analysées à l'aide d'une approche thématique, incluant le débriefing des entretiens, le codage des transcriptions, la présentation des données et l'interprétation.

Résultats

Nos résultats comprennent cinq thèmes : 1) Les réflexions des enfants réfugiés sur leur bouche ; 2) Leurs expériences à la clinique dentaire; 3) La perception par les parents de la santé buccodentaire ; 4) Les expériences des parents pour accéder à des soins buccodentaires pour leurs enfants ; 5) Les expériences des parents après avoir accédé à des soins buccodentairespour leurs enfants.

Les enfants réfugiés établissaient un lien entre la santé buccodentaire et l'apparence dentaire,et avec des symptômes tels que la douleur dentaire et l'halitose. Ils associaient aussi la santé buccodentaire aux soins préventifs, y compris l'alimentation, l'hygiène orale et les visites chez le dentiste. Concernant leurs expériences à la clinique dentaire, la plupart des témoignages étaient positifs, les enfants ajoutant qu'ils étaient prêts à consulter à nouveau. Cependant, en raison

d’inconforts et de la peur de la douleur pendant les procédures dentaires, certains appréhendaient les visites de suivi.

Les parents appréciaient l’importance de la santé buccodentaire, même s’ils manquaient de connaissances sur la couverture de santé buccodentaire et d’informations sur les institutions qui fournissent des soins aux personnes réfugiées. Les parents ont également rapporté des obstacles liés au transport, à une couverture dentaire limitée et à la langue, bien qu’ils aient également exprimé leur satisfaction à l’égard des services fournis à la Clinique dentaire pour immigrants et réfugiés. Cette satisfaction était liée à sa propreté, à la qualité du matériel, aux faibles délais d’attente le jour du rendez-vous, ainsi qu’à la courtoisie du personnel de la clinique.

Conclusion

Nos résultats sont utiles pour les professionnels dentaires et les institutions impliquées auprès des personnes réfugiées, qui sont bien placés pour améliorer leur accès. De plus, ils devraient alerter les organismes gouvernementaux et communautaires sur l’importance de mieux informer et guider les personnes réfugiées. Des recherches supplémentaires devraient se concentrer sur les perceptions des professionnels dentaires impliqués auprès des enfants réfugiés afin de comprendre leurs expériences et leurs suggestions pour améliorer l’accès.

1. Introduction

The migration of people is a worldwide phenomenon. People migrate for professional, economic, educational, and family reasons; further, sometimes they are forced to migrate to escape war, conflict, and persecution (2). From 1990 to 2019, 119 million people migrated worldwide, of which 25.9 million were refugeed persons (3). Refugeed persons are those who have been forced to leave their home country and seek refuge in other countries due to conflict, persecution, or war (4). Even more concerning is that roughly half of them are under 18 years of age (5).

Canada is one of the leading host countries in the world for refugeed persons. Since 1980, over 1 million have arrived in Canada (5), which is approximately 25,000 people yearly (6). The province of Quebec plays a significant role in this resettlement as it welcomes about 20% of these persons, more than half of whom resettle in the largest city, Montreal (6).

Refugeed persons face countless challenges after their arrival, such as learning a new language and adapting to a different culture and society (5); some arrive in poor health and require urgent or long-term care (7). Studies have shown that in addition to contagious diseases (e.g., HIV or hepatitis B) and chronic diseases (e.g., anemia and hypertension) being prevalent among newly-arrived refugeed persons in Canada (8, 9), there is a high prevalence of oral health-related issues, especially dental caries, and gingivitis (7, 10).

Access to oral health care services may be difficult for the refugeed population, and one of the reasons is that once they arrive in the host country, they need to learn to navigate the healthcare system (7). Furthermore, they often arrive with depleted financial resources (5), making access to oral health care challenging as they often need to pay out-of-pocket (11-13).

In Canada, the Interim Federal Health Program (IFHP) is a government-funded program for refugeed persons that provides them with limited healthcare for 12 months. The IFHP partially covers dental care, limited to treatments for relieving oral pain (14, 15). Since 2019, the program has covered restorative treatment and extractions, with allowable costs up to CAD 1000; stainless steel crowns, endodontic treatment, examinations, and prevention are not covered (15).

In Montreal, refugeed children up to 10 years of age can receive free comprehensive oral health care at the Student Dental Clinic for Pediatric Dentistry at the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital. This clinic is a collaboration between the Division of Dentistry of the Montreal Children's Hospital and the Faculty of Dentistry at McGill University. In it, senior McGill dental students provide the services under the supervision of hospital staff dentists (16).

Research has not yet fully explored how refugeed children in Canada understand oral health and experience oral health care, nor how their parents experience accessing oral health care for them. Given this gap in knowledge, this study was designed to begin to explore these issues. The overall goal is to contribute knowledge towards improving refugeed persons' access to oral health services and, ultimately, their oral health. This study was conducted in Montreal, and sought to answer the following question: "How do refugeed children in Montreal understand oral health and experience oral health care, and how do refugeed parents experience accessing oral health care for their children?"

1.1 Interest in the topic

As a dentist from India, I have always had a keen interest in oral health and have been eager to learn more about underprivileged people in order to help them. I became interested in this particular research topic after learning about the work of Dr. Mark Tambe Keboa, a former PhD student at the Faculty of Dentistry of McGill University. His work and my initial literature search revealed that further research was needed to shed more light on the experiences of refugeed persons to improve their access to oral health care and strengthen research on the oral health of refugeed children (7, 14). My supervisors, who initially introduced me to this research topic, also helped me better understand the complexity of this issue in Canada.

1.2 Outline of the chapters

In the following chapter, I explain which persons are considered refugeed persons and define the concepts of oral health, oral health care, and access to care. This chapter also provides background information about the IFHP, refugeed persons, refugeed children in Canada, their oral health status, and how it compares with native-born children. It describes their barriers to health and presents the limited scientific literature on refugeed persons' perceptions about oral health care and accessing care. This chapter also outlines the gaps in the literature and states the study's aim, objectives, and research question.

The following chapter presents the research methodology, sampling strategy, data generation and analysis, and ethical considerations. The fourth chapter describes the results, describing the viewpoints and experiences of refugeed children about oral health and receiving dental care, and their parents' experiences about accessing oral health care for their children. Our analysis produced the following themes. The first

highlights how children understand oral health based on their reflections of their mouths, their oral health practices, and the symptoms they or their friends have experienced. The second theme refers to their experience at the dental clinic in Montreal. Regarding the parents, the themes focus on their understanding of oral health, their challenges before finding access to oral health care for their children, and their experiences after finding care.

The final chapter discusses our findings in light of current literature and the limitations of our study. It also provides recommendations for the Immigrant and Refugee Pediatric Dental Clinic staff at the Montreal Children's Hospital and proposes directions for future research.

2. Literature Review

This chapter starts with an overview of refugeed persons, including the types of refugeed persons, their oral health, and their access to oral health care. It then presents the IFHP, which provides limited and temporary health coverage to newly admitted refugeed persons in Canada who are not yet eligible for provincial health coverage and do not have private health coverage. This chapter also discusses immigration in Canada and describes the limited literature on the oral health care experiences of refugeed parents and their children in Canada.

2.1 Explanation of key terms and definitions

2.1.1 Refugeed persons

Human migration is the temporary or permanent displacement of individuals or groups from one geographic location to another (17). The reasons for human migration vary, including seeking a better job, receiving health care, and escaping persecution, poverty, conflicts, and violence (2). As opposed to a purposeful migration strategy, for example, when people migrate to pursue economic and social prosperity, refugeed persons are those who have been forced to migrate due to conflict, persecution, or war and seek refuge in another country (4). In Canada, refugeed persons are classified into two categories:

1. Convention refugeed persons are granted refugee status before arriving in Canada and are recognized under the United Nations Convention for Refugees. The 1951 Refugee Convention is a legal document that defines refugeed persons, outlines their rights, and states the countries' legal obligations to protect them. Convention refugees include:

- Government-assisted refugees: They are sponsored by the federal government to resettle in Canada and receive financial support from the federal government during their first year of resettling.
- Privately sponsored refugees: These individuals travel to Canada on a permanent resident visa and are sponsored to resettle in Canada, receiving financial support from individuals or private organizations.

2. The Domestic Asylum Program includes :

- Refugee claimants: people who have applied for protection and are awaiting a decision from the government at the borders of Canada. Refugee claimants are also known as asylum seekers.

  Inland refugees are already present inside Canada and have an approved application for refugee protection.

2.1.2 Oral health

The World Dental Federation (FDI, Fédération Dentaire Internationale) states that “oral health is multifaceted, and includes the ability to speak, smile, taste, touch, chew, swallow, and also conveys a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex” (18). For this study, this definition was adopted to relate to the oral health experiences of refugeed persons, as it highlights the important relationship between disease and physiological and psychological function and its influence on overall well-being.

2.1.3 Access to oral health care

Oral health care includes oral health treatments to prevent, diagnose, and manage craniofacial diseases (14). It includes the combination of personal oral

hygiene and professional oral health care to maintain oral health (14). Penchansky defined the concept of access as “a concept representing the degree of ‘fit’ between the clients and the system,” and viewed access as “the general concept that summarizes a set of more specific areas of fit between the patient and the health care system” (19). Penchansky described access as a multi-dimensional concept that comprises five dimensions (19): availability (the adequacy of the healthcare providers, accessible clinics/hospitals, and availability of healthcare and emergency care services); accessibility (resources such as transportation, time, and costs to travel to the healthcare center); accommodation (organization of supply resources such as availability of appointments, working hours of the care providing institution, and communication services related with fulfilling the health care needs of the healthcare seeker); affordability (financial aspects such as income, ability to pay, and health insurance required to use the healthcare services); and acceptability (the healthcare seekers’ assessment of the healthcare provider) (19).

2.1.4 The Interim Federal Health Program

Developed in 1957 by the Canadian federal government (20), the IFHP provides limited and temporary healthcare coverage to newly-arrived refugeed persons for their first 12 months (21). Under the IFHP, newly-arrived refugeed persons are eligible for urgent dental care during their ineligibility for provincial or territorial health insurance (21). Dental benefits include emergency dental examinations once every six months per dental office, diagnostic radiographs (periapical and bitewing radiographs to a maximum of 16 radiographs per lifetime and one panoramic radiograph limited to once per lifetime), restorative treatments and extractions (up to CAD 1000), pain management from caries or trauma, and medication for emergencies

(22). While many refugeed persons arrive in Canada with poor oral health conditions and high needs for dental treatments (7, 14), their oral health needs may remain unmet given the limitations described above (23).

2.2 Immigration in Canada

Canada has accepted refugeed persons for decades (24), surpassing 700,000 individuals in the last 40 years (25). The country has a legal obligation to protect these persons' human rights and well-being after signing international conventions that protect their rights (26). The United Nations Committee on Economic, Social, and Cultural Rights, in particular, stipulates that all individuals have the right to access standard care (26).

2.2.1 Health status of refugeed persons in Canada

Refugeed persons mostly originate from developing countries where disease prevalence is often high (27), and the difficulties they encounter during their migration may further exacerbate their health issues (28). Refugeed persons in Canada often have urgent healthcare needs and experience poorer health than native-born Canadians (29, 30). Many arrive in Canada with infectious or chronic diseases such as hepatitis B, HIV, anemia, and high blood pressure (8, 9, 27). Refugeed persons are also at a higher risk of developing cardiovascular diseases after arriving in host countries (31, 32), which are known to be associated with oral diseases such as periodontitis (33). In brief, poor oral health may increase the risk of systemic diseases and vice versa (14, 34).

2.2.2 Oral health status of refugeed persons in Canada

Some refugeed persons experience oral health-related problems that may, as just mentioned, be linked with systemic diseases and decrease their quality of life (35). The literature suggests that the high oral needs of refugeed persons are an outcome of underdeveloped health care systems and limited access to oral health care services (36, 37); it may also be an indirect outcome of the complex and precarious situations of their lives, including war, persecution, and economic difficulties (38-42).

Taking advantage of oral health care services in the host country can also be challenging for refugeed persons as they are still unfamiliar with the available resources and navigating the healthcare system (14). Additional barriers to accessing healthcare include language, cultural differences, and precarious legal status (43). Language may indeed be an issue for refugeed families and lead to difficulties in obtaining information and interacting with clinicians and dental staff (43). Similarly, cultural differences may hinder access, and health care providers may not be aware of the experiences of refugeed persons (43). Refugeed families may also avoid accessing oral health care services because of their sometimes precarious legal status in Canada and the fear of deportation (43).

The limited literature on the oral health of refugeed persons in Canada suggests that they encounter numerous barriers in accessing dental services (14, 43-47) and experience various oral health problems (7, 10, 14, 43-47). For example, a study with newly arrived immigrants and Bhutanese refugeed persons aged between 18 – 67 years in Nova Scotia revealed high oral health needs, including caries, severe gingivitis and periodontitis (10). Another study, conducted with Government Assisted Refugeed persons aged between 3 – 67 years living in three communities in southern British Columbia also reported high prevalence of oral diseases, including temporo-

mandibular pain, high oral health care needs and lack of access to care services (46). A study in two major cities in Ontario involving adult refugeed parcipants also suggested high unmet oral needs needs (47). Studies from Quebec concur with the above mentioned studies (7, 14).

2.2.3 Oral health status of refugeed children in Canada

Out of the approximately 25,000 refugeed persons admitted in Canada each year, roughly 40% are younger than 15 (48). During their migration, refugeed children are known to face complex situations that vary from displacement from their homes to the absence or even death of their parents (49). Consequently, they may experience health conditions such as depression, anxiety, and behavioral problems with potential long-term implications (50).

Although the availability of literature concerning the oral health of refugeed children is limited, global research demonstrates that refugeed children have high unmet oral health care needs and experience problems such as dental caries and chronic gingivitis (38, 50, 51). These issues may affect their speech, eating habits, and school performance, as well as their general growth and well-being (52, 53). While there is a dearth of research on oral health among refugeed children in Canada, there is some literature to draw from that corroborates with the above findings (16, 54-57). Canadian studies also suggest that refugeed children experience poor oral health conditions, such as early childhood caries, tooth decay, missing teeth, high plaque accumulation, chronic gingivitis, and malocclusion (16, 54-57); these conditions may lead to nutritional deficiencies, and eventually to poor oral outcomes in adulthood (58). A study in Edmonton, for instance, suggested that refugeed children arriving from Northeastern and Western Africa had untreated dental caries (59). Two other studies

in Manitoba outlined that refugeed children had a high prevalence of early childhood caries, advanced tooth decay, and the need for dental care (55, 57). Similarly, a study in Saskatchewan suggested that refugeed children might be more susceptible to dental problems than Canadian-born children given their high prevalence of dental caries and poorer oral health (56).

2.2.4 Oral health status of refugeed children in Montreal

The Government of Quebec actively participates in refugee resettlement programs, with over 60,000 refugeed persons resettled in Quebec from 2000 to 2010 (14). Quebec admits about 20% of the refugeed persons in Canada every year, and approximately 67% of them resettle in Montreal (54).

The Government of Quebec provides free dental care to children below 10 years of age (60); yet, one study reported that children in Quebec have roughly 50% more cavities than other children in North America (61). Furthermore, other studies have also suggested that refugeed children in Quebec experience problems related to oral conditions (16, 61, 62).

A retrospective study conducted at a pediatric clinic specifically for refugeed children in Quebec compared the oral health status of refugeed children to Canadian-born children using different variables, such as their last dental visit, history of caries (decayed, missing, and filled teeth [DMFT] index), plaque accumulation, gingival condition, and malocclusion. The results showed that the refugeed children experienced poor oral health, given that they had higher DMFT scores, a higher prevalence of gingivitis and decayed teeth, and more common anterior crossbite than Canadian-born children. The authors concluded that access to appropriate oral health

care for refugeed children must be a key priority for health care providers and policymakers (16).

2.2.5 Access to health services and sources of health care information for refugeed persons in Canada

Navigating healthcare services is a major factor associated with access to care (63). In Canada, limited access to healthcare due to language, cultural and systemic barriers results in poor health outcomes for refugeed persons (64, 65). Newcomers, including refugeed persons, face many challenges in accessing care compared to the native-born population in Canada (29). Evidence has suggested that refugeed persons face numerous challenges in Canada compared to their home country, making access to such services difficult (14). These challenges are related to living with low-incomes, the expensive costs of dental services, language barriers, cultural differences, and transportation issues (43, 66).

Refugeed persons in Canada may lack knowledge about the available oral health care resources for them (44). Sources for information include social workers and community leaders , as well as friends, neighbors, general health practitioners, and school teachers (14). In contrast, for those who do not possess adequate information, emergency room services can serve as a last resort to access health care (62).

2.3 Limitations of available literature and knowledge gap

It is evident that many refugeed persons, including refugeed children, have poor oral health and require oral health care upon arriving in Canada; nonetheless, little is known about their oral health care experiences (7, 14). The current literature does not

explore their experiences accessing oral health care. Such research is needed to know their first-hand experiences and any challenges they face while accessing oral health care; such evidence could help improve their access to oral health care services and eventually improve their oral health outcomes in Canada.

A Canadian study by Beiser (1995) focused on the hardships that migrant children faced before and after arriving in Canada and the physical and psychological health problems they experienced (67). While this study did not demarcate refugeed children from immigrant children, nor explore their oral health status and difficulties faced, its conclusions remain important: that additional research on the health of migrant children in Canada is needed for policy development and service planning according to their needs.

The current literature on refugeed people in Canada explores access to dental care of adults, and there is no known study focusing expressly on refugeed children's experiences of oral health, nor access to oral health care. The available studies suggest that the high cost of dental care, insufficient government-assisted dental coverage, traditional beliefs of refugeed parents, and limited parental knowledge of oral health and practices are the key factors in determining the oral health status of refugeed children (68-70). However, these studies do not fully cover other perspectives, including oral health understandings of refugeed children and their oral health care experiences while receiving oral care. In addition, these studies are generalized and draw upon the people from underprivileged minority groups and migrants (44, 56, 57, 59, 62, 68, 69, 71); they are not specifically conducted with refugeed people.

2.4 Children's voices and experiences

Efforts to understand the views and experiences of children regarding oral health and oral health services have been increasing worldwide (72). Although children are viewed as active agents within the interdisciplinary field of childhood studies (73), their participation remains minimal in dental research (72). Dental research is done *on* children, not *with* them (72, 74). More precisely, involving children in research reflects children's experiences and concerns (74). Thus, it is crucial to include children's voices and experiences in research to shed more light on their perspectives and improve their outcomes (72, 74).

Thus, it is important to explore the oral health experiences of refugeed children, to understand their perspectives, including their positive experiences and their hardships during oral health care. Such findings will be useful to better train dental care providers and help community organizations to improve access and ultimately promote refugeed people's oral health.

2.5 Defining the problem

Canada accepts many refugeed people each year (5) who often require urgent healthcare given the high incidence of diseases (8, 9). As mentioned above (section 2.2.1), despite existing data on the general health of refugeed people arriving in Canada, little is known about the oral health experiences and health-related difficulties refugeed people face after resettlement (10, 14, 26). Once refugeed people arrive in the host country, accessing oral health care in an unfamiliar system can be challenging. Several factors, such as healthcare policies, the healthcare system, and personal beliefs, affect their oral healthcare services navigation (7). Newly-arrived refugeed people in Canada have limited financial resources (5), and the literature

suggests that oral health care can be expensive (11). In Canada, the IFHP remains the only government-funded healthcare program available for refugeed persons, albeit it only partially covers their oral treatment expenses for 12 months (15).

Oral problems affect vulnerabilized persons, including children from minority groups and economically challenged families (75). Indeed, refugeed children face poor oral health outcomes and a high prevalence of dental diseases and caries (76). Furthermore, they often face numerous barriers in accessing dental care services upon arriving in the host country (71, 76).

2.6 Research gap

Approximately 25,000 refugeed persons resettle in Canada every year, 50% of which are children. Many refugeed children arrive in Canada with high oral health care needs, and they have limited access to oral health care once they arrive. Hence, it is crucial to explore their perspectives and learn more about their experiences in accessing oral health care in the host country to improve their access to oral health care, ultimately promoting their oral health. Research has not yet explored refugeed children's understanding of oral health care and experiences in Canada, nor their parents' experience regarding accessing oral health care for them. With the results from this study, I endeavor to contribute to filling this knowledge gap.

2.7 Research question

The study's research questions are: "How do refugeed children in Montreal understand oral health and experience oral health care, and how do refugeed parents experience accessing oral health care for their children?"

2.8 Objectives

a) To explore how refugeed children in Montreal understand oral health and how they experience oral health care.

b) To explore the experiences of refugeed parents regarding accessing oral health care for their children in Montreal.

3. Methodology

3.1 Research design

In research, a qualitative approach is the best methodology to address ‘how’ and ‘why’ questions relating to human views, experiences, and perceptions (77). The inductive approach of qualitative research is also best suited for exploring people’s experiences (77). My aim with this study was to explore ‘how’ refugeed children understand oral health and experienced oral health care and ‘how’ their parents accessed oral health care. Hence, I adopted a qualitative design based on the research question and objectives (78).

Among the various qualitative methodologies, qualitative description is useful in health research because it enables focusing on the experiences of patients, relatives, and professionals and their views on patient-professional interactions (77). This methodology was deemed appropriate as it facilitated the exploration of the experiences of refugeed children and their parents’ perspectives on access to care.

3.2 Sensitizing constructs

Following a qualitative description methodology (79), I employed two sensitizing constructs as lenses to approach my study design and data analysis.

3.2.1 Childhood ethics

In research, children are often considered incapable of making their own decisions and must be protected by adults (80, 81). This concept is challenged by Childhood Studies, where scholars have argued that children have the right to express their views and that their views should be given due weight according to their age and

maturity (82). Some oral health researchers have begun actively involving children in research, seeking their perspectives (72).

The current literature suggests that actively involving children in research allows us to better understand their experiences and concerns and that hearing their voices is pivotal to learning about their perspectives (72-74, 80). Montreuil and Carnevale have advanced a theory of Childhood Ethics that commits to the importance of supporting children's agency in health decisions. This framework is suitable for studying children's engagement with their health and experiences within health care settings, and has been adopted in this study.

3.2.2 Access to care

Given the lack of conceptual frameworks specifically addressing the oral health care experiences and access to oral health care of refugeed parents and children, I adopted Bedos and colleagues' model of the dental care process as a conceptual map (Figure 1) (83). This model is an adaptation of a framework originally developed by Grembowski (84). The participants for my project were similar to Bedos et al's regarding economic vulnerability, making this model an appropriate choice.

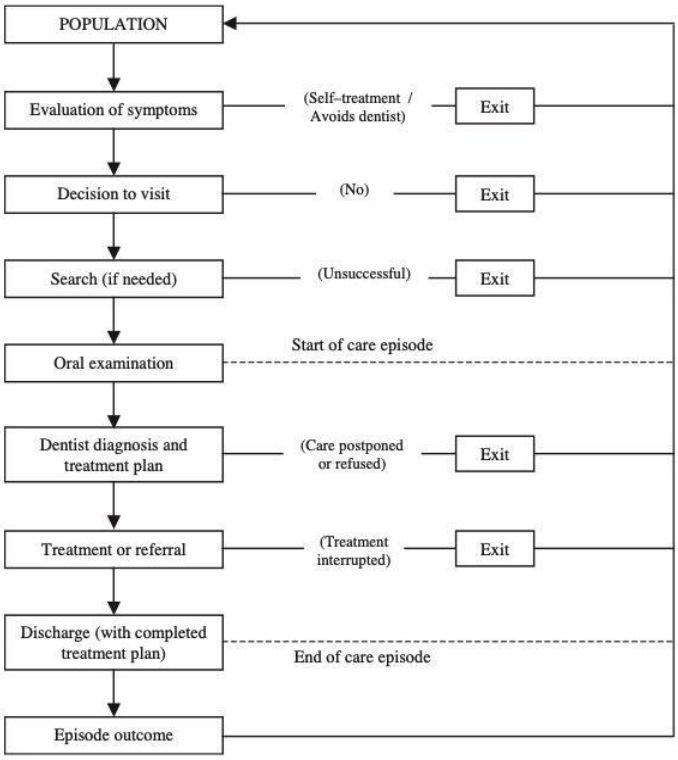

Figure 1: Conceptual framework (83)

This model describes a process that comprises two different phases. The first represents people's pathway before using dental services, and the second is the care provided. For my study, I have adopted it as follows: the first phase predominantly involves the oral health understanding and knowledge of the refugeed parents and the processes they go through and barriers they face before visiting the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital. The second phase starts when parents and their children enter the dental clinic, and includes barriers and facilitators to care, and their child's experiences at the clinic.

I used this framework to develop the interview guide, and to guide data analysis and interpretation. It provided the deductive codes to analyze the interview transcripts and guided the thematic analysis and presentation of the results.

3.3 Data generation methods

3.3.1 Sampling

The sample of parents and children was recruited from the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital. This is a particularly important local institution as it is the only one in Montreal that provides comprehensive free dental care for refugeed children. The clinic is open from September to April and during August. Dental students provide the treatment in their last year of training under the supervision of the Montreal Children's Hospital licensed dentists.

I adopted a purposeful sampling technique to include a range of experiences varying with age, gender, country of origin, and duration of stay in Canada. Purposeful sampling is used in qualitative research to identify and select cases rich in information and related to the interest of the study (85).

3.3.2 Inclusion and exclusion criteria

While the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital serves refugeed children until age 10, I was informed that some older siblings, up to the age of 12, were also provided with care. Consequently, I decided to include children up to 12, assuming that older children may have more experiences to share than younger ones. I also decided to exclude children under 6 because they are less able to fully understand and respond to interview questions.

The following inclusion criteria were used: 1) Children 6 to 12 years of age; 2) Parents or guardians of the participating children; 3) Participants able to communicate in English, Hindi, or Punjabi (this criterion was set because I only speak these three languages). The exclusion criteria included children with medical conditions (e.g.,

hearing impairments and Down syndrome) who may not communicate easily during the interview process.

3.3.3 Recruitment

Two recruitment strategies were used. Firstly, flyers in English and French (Appendices A and B) advertising the study objectives were placed inside the clinic, waiting area, and conference room. Secondly, I made myself available in the waiting area of the clinic before the scheduled time of the first treatment appointment and remained there until the last scheduled appointment of the day. I approached every family in the waiting area and, following their permission, explained to them the purpose of the study and the participation criteria.

Although most families listened to my explanations and expressed interest, six out of the nineteen who were eligible did not participate. Four of these six refused because they were concerned that their participation might affect their residence status in Canada, and two mothers refused as they first wanted to consult with their spouses. There were two families who were willing to participate, however they did not speak the study languages fluently enough to participate.

3.3.4 Interviews

Before commencing the interview with parents, the parents were thanked for participating. Then, I introduced myself and explained my role in the study. I also reminded them about the objectives of the study and its potential outcomes. After this initial briefing, I asked the parents if they had any questions. Then, I provided them with the consent form (see Appendices C and D) and asked them to carefully read it before signing.

Children were approached after their parents provided consent to interviewing them alone. I greeted the children and introduced myself, followed by asking them several questions, such as their name, age, and how they felt, to put them at ease. A verbally informed assent was obtained from the children before their participation. To obtain assent, I asked them for their permission to ask them a few questions alone (without their parents). I explained the research topic in a simplified way and assured them that their responses would not be shared with anyone and that they had the right to withdraw from the study whenever they felt uncomfortable. This process of informed assent involved children as active participants and ensured their control, especially regarding their participation (86).

Individual, face-to-face, semi-structured interviews were conducted to facilitate in-depth conversations and describe the participants' experiences thoroughly (87). Eleven families (11 children and one parent for each child) participated, and the interviews lasted 30–40 min with the parents and about 20–30 min with the children. Interviews with children and parents took place separately to avoid parental influence and to obtain children's first-hand opinions about their experiences. The parents were interviewed while their children received treatment in the dental clinic, and the children participated after their clinical encounter. The conversations with children were purposely organized after their treatment as some were consulting for the first time and thus would not have any prior experiences to share.

To maintain confidentiality, all interviews took place in a private room away from the waiting area. They were audio-recorded with the written consent of the parents and children. I began each interview by asking the participants if they felt at ease. If not, I verified any concerns they may have and tried to resolve them before advancing. With the parents, I started the interview process by asking for their names and other

socio-demographic information (e.g., country of origin, their time of arrival in Canada, and the number of children they had); I then moved on to their experiences and their process of accessing oral health care in Canada.

For instance, I started with questions such as “When did you arrive in Canada?” and “How many children do you have?” Then, I asked them various questions to explore their perspectives about oral health, including “What do you understand by the term oral health?” and “How would you define oral health?” Regarding access, I used questions such as “What type of health coverage plan do you have?” “How did you learn about this plan?” “Have you encountered any dental emergency for your children?” and “How did you learn about this institution (MCH)?” Finally, to learn about the barriers they may have faced, I asked questions such as “What types of barriers have you experienced accessing oral health care for your children?”

Similarly, I began the interview with the children by asking their names, ages, and opinions about oral health. I then explored their perspectives about oral health with questions such as “What do you think about your mouth?” “What do you think about your teeth?” and “Do you have friends who have healthy or unhealthy mouths and teeth?” To learn about their perception of oral health care, I asked questions such as “When do you go to see the dentist?” and “Who decides when it is time to go to the dentist?” Finally, questions such as “What happens when you see the dentist?” “How did you feel?” and “Would you like to go to the dentist again?” allowed me to learn about their dental care experiences. Please refer to the interview guides (Appendices E and F) for additional information.

The interview guides for parents and children were designed with the help of my supervisors, Dr. Macdonald and Dr. Bedos, and my thesis committee member Dr. Beatriz Ferraz Dos Santos. I drafted them, keeping the study’s research question in

mind, and with the help of the sensitizing constructs mentioned above. For instance, the concept of children's agency was used while designing the interview guide for children. The concepts embedded in the dental pathway were used while developing the interview guide for parents. Most questions were open-ended to encourage the participants to share their experiences and perspectives in detail. After the first two interviews, I rearranged the sequence of questions in the guides to better facilitate the flow of the discussions.

Several strategies were also utilized to generate data from the participants. As mentioned, I asked open-ended questions and listened carefully to their experiences; I also used verbal probes such as "that's good," "oh!" and "really?" as well as non-verbal expressions such as nodding and looking at the participants while they spoke.

After completing the interviews, the parents and children were thanked for their participation and gifted a $20 Walmart gift card and small toys as a form of gratitude.

3.4 Data analysis

Data generation and analysis occurred concurrently. I completed an interview report form created by Dr. Macdonald (Appendix G) within 24 h of each research encounter to facilitate analysis and reflexivity. Reflexivity is focused on making explicit and transparent the effect of the researcher (88), methodology, and data generation tools on the research process and results (89). The interview report form was the initial step for data analysis, in which I reflected on the interview data. This reflection helped me identify the concepts in the data that were relevant to the research question and explore them better in future encounters (90). I transcribed all interviews (including interviews with 7 families in English and 4 families in Punjabi) in Microsoft Word files.

The next step of data analysis was to code the transcribed interviews. I assigned codes to all the available data using the Summary and Analysis coding approach developed by a qualitative research team at McGill University (www.mcgill.ca/voice/). With the Summary and Analysis technique, each relevant data segment was assigned a summary code (to explain the excerpt inductively) and an analysis code (to inductively and deductively interpret the phenomenon where pertinent). The literature review, research question, and sensitizing constructs helped me create the deductive codes. At the same time, I developed the inductive codes from the data directly.

Codes were then aggregated to form categories (91), and the categories were sorted, always with relevance to the research question. Two summaries were then written: one for the interviews with the children and the other for the interviews with parents; similar descriptive categories and codes were also combined. My thesis committee members reviewed the data summaries to ensure rigorous representation before progressing towards the next analysis step. With the help of my thesis committee members, I interpreted the categories from the combined data summaries and developed the themes. These themes described the oral health understandings and experiences of refugeed children and their parents accessing oral health care. I described them in detail in the results section of the thesis. (Note: Table 3 and Table 4 in Appendix H and I provide examples of the analytic process).

3.5 Ethical considerations

This study was conducted according to the ethical principles of the Declaration of Helsinki (2013) and with permission from the Research Ethics Board of the McGill University Health Centre. All the necessary information, including the study's

objectives, was explained to all the participants. The information was also mentioned in the parents' consent form before the interview; they were given time to read the consent form before signing it. In Quebec, minors below 14 years cannot sign consent forms themselves. Hence, the parents signed the consent form, and assent was obtained directly from the children (as described above). The parents and children were informed that their participation was voluntary and that they could opt out at any time and for any reason. The participants were duly informed that they had the right to refuse to answer any question at their discretion. However, this did not happen during the data collection process.

All necessary measures were taken to protect the participants' privacy. For example, the audio recordings were destroyed after transcription. Alphanumeric codes were assigned to the transcribed participant data, and the participants' names and identities were kept confidential. The codes were stored in a separate password-protected Microsoft Excel document, and access to this document was shared only with the McGill supervisors. All transcripts, field notes, and other written data were stored in password-protected files in Microsoft Word. Only the student researcher and supervisors had access to these documents. The exchange of transcripts or any other communication related to the study was done through the McGill OneDrive platform. Hard copies and electronic data (stored on a password-protected and encrypted external drive) will be stored in a secure cabinet with Dr. Macdonald for seven years after the publication of the thesis.

4. Results (child participants)

The following chapter describes the findings from the children's interviews, addressing how they perceived oral health and experienced oral health care.

Description of the participants

Eleven children were interviewed for this study. The interviews were conducted in English and Punjabi, and lasted between 20 and 30 minutes. The sociodemographic data from these participants are listed in Table 2.

Table 1: Sociodemographic profile of the children participants

Characteristics	Categories	Number of participants
Age	5 years	1
	6 years	1
	7 years	4
	8 years	2
	9 years	2
	10 years	1
Gender	Male	5
	Female	6
Country of origin	India	4
	Jamaica	1
	Mexico	1
	Egypt	1

	Not reported	4
Language of the interview	English Punjabi	7 4

Two main themes were constructed from the analyses: children's reflections on their mouths and their experiences at the dental clinic.

4.1 Children's reflections on their mouths

The children reflected on the condition of their teeth and mouth in different ways. They mentioned their dental appearance, the absence or presence of symptoms, their individual and family oral health practices, and their methods for preserving their oral health.

4.1.1 Dental appearance

When invited to describe their teeth and mouths, the dental appearance was an important element for children; most responded by referring to their teeth color and alignment. White teeth made them consider their teeth clean and healthy, as explained by a five-year-old girl: "*They are clean because they are white.*" Similarly, a ten-year-old girl shared her thoughts about her friends' teeth, which she described as being healthy because of their white color: "*Sometimes when they speak, their teeth look good, their teeth are okay, white, and nice. They are white."*

Although having white teeth was an important factor, some children normalized extrinsic discolorations by referring to yellow teeth as normal. A nine-year-old girl, while reflecting on appearance, shared that one of her friends had "slightly yellowish" but "normal" teeth:

"His teeth are slightly yellow. They are not very yellowish. They are just slightly yellowish. I just noticed that his teeth are yellow when I saw his teeth along with the teeth of my other friends, whenever they speak or laugh. But slightly yellow teeth are normal. Slightly yellowish teeth are almost same as the white teeth. Very hard to spot the difference."

Some children also thought having yellow teeth could be fine unless dental caries were present. For example, a ten-year-old participant describing her friends' teeth mentioned:

"I think their teeth are good. I think it's okay if they have yellow teeth, well, it's okay. People have yellow teeth; people have white teeth, it's okay. Yellow teeth are not bad unless they have cavities in them."

In contrast, dental caries and malocclusion made children think their teeth were not healthy and clean. Interestingly, some restorative treatments, such as amalgam restorations and stainless steel crowns, were associated with poor oral health. For instance, an eight-year-old girl said, *"Some of my friends have clean teeth, and some do not, as some of them have metal in their teeth, and it's not good. Their teeth appear metallic, so not good teeth."*

Dental malocclusions and diastema were also perceived as poor oral health. For example, when a nine-year-old girl was asked about her mouth and teeth, she replied by saying:

"When I smile, some of my teeth become visible, and I don't like the position of those teeth. In the part of my mouth where those teeth are visible when I smile, I think that part is not good. The rest of my mouth is good and healthy. And because they don't look good when I smile. Two

of my front teeth are placed outwards, I don't like them. I think they are not healthy".

Another child mentioned that one of her friends did not have clean teeth because of generalized spacing ("gap between his teeth") and diastema.

4.1.2 Absence or presence of signs and symptoms

Children associated the condition of their mouth with the presence or absence of signs and symptoms such as tooth pain, halitosis, and "bad taste in the mouth." Some children linked tooth pain with poor oral health, as illustrated by a child referring to his tooth pain: *"I have pain in some of my teeth, so my mouth is not good because of that."* Children also believed their teeth and mouth conditions were poor because of dysgeusia. For example, a five-year-old girl said, *"Sometimes when I drink juice, I get a bad taste in my mouth. So, my mouth is bad."*

4.1.3 Methods and practices for maintaining oral health

Most children thought their health practices, including oral hygiene and nutritional behaviors, accounted for their mouth and teeth conditions. Some mentioned that good oral hygiene practices, such as brushing regularly and healthy eating habits, were responsible for their healthy mouth and teeth. For instance, a seven-year-old girl thought her mouth was healthy because she brushed her teeth regularly. Another child said that a good diet was responsible for his good oral health: *"My mouth is healthy because I drink a lot of water, eat vegetables like broccoli, and brush my teeth."*

When asked about what could help them have good teeth and mouth, most children answered the question about visiting the dentist regularly and linked their

regular visits with their mouth and teeth conditions. A nine-year-old said, *"I think that people who don't visit the dentist regularly have bad teeth."*

4.2 Experiences of children at the dental clinic

Children shared their experiences of receiving oral health care, including their understanding of their treatment plan and its benefits. The type of treatment they received and their experience during their appointment with the dentist were factors associated with their willingness for follow-up visits.

4.2.1 Awareness of the treatment procedure during a visit to the dentist

Most children were aware of the procedures carried out by the dentist in the dental clinic. They described the treatment they received, such as a dental examination, "cleaning," "photographs" (referring to radiographs), or "fillings." A nine-year-old reported:

> *"Dentist checked my teeth and cleaned them. Then they applied something on them, blue in color. They did the same thing during last two times."*

Some participants knew the steps of their treatment procedure and even mentioned clinical terms during their interview. For example, a seven-year-old boy said, "*the dentist checked my teeth, cleaned them with water, and then took an X-ray*." When asked about the X-ray, he explained, "*X-ray is like when the dentist click a photograph of your teeth on a film to check the bone and stuff."*

4.2.2 Willingness for follow-up visits based upon positive experiences at the dental clinic

Most children reacted positively to their follow-up visits and were willing to visit the dentist again. Their awareness of the importance of visiting a dentist, acceptability of dental procedures, receiving a gift after the dental appointment, and the kind behavior of the dentist positively affected their willingness for future dental visits.

Children understood the importance of visiting the dentist and said they would like to consult again to improve their teeth and mouth conditions. For instance, a child mentioned he was feeling better after the visit and said, *"Dentist cleaned my teeth and they are better now."* Similarly, an eight-year-old boy, when asked if he would like to visit the dentist again, replied, *"I will come. I just want to show them my teeth to keep them clean."*

Despite voicing concerns regarding some specific procedures, children still said they would be willing to visit the dentist again. Some said they liked the dental apparatus at the clinic and the instruments used during treatment. A participant even explained he liked sitting in the dental chair and wanted to take it home to watch TV as it was very comfortable. Another, while referring to the saliva ejector at the clinic, said, *"I will visit again because I like when they use that thing with water and something to make the spit go away."*

Children received rewards such as stickers, small toys, and toothbrushes at the end of their dental visits, which positively impacted their willingness for follow-up visits. For instance, an eight-year-old girl said, "*Yes, I am happy and I can come again if I will get the stickers and surprises next time too after seeing the dentist."*

Most children appreciated being treated kindly and respectfully at the clinic. They mentioned that the polite and generous nature of the dentist and staff

encouraged them to come back in the future. For example, a nine-year-old girl shared her experiences:

> *"The dentist was good too because they spoke with me very well and they were very polite. I am feeling good. When they started my treatment today, there was a sharp object that hurt my tooth when they started the treatment. I made a noise in pain. They said sorry to me. I really liked that because all doctors give you pain but they never apologize. Then they treated me with care and there was no pain afterwards."*

Children also valued communicating with the dentist in their native language. For example, a participant highlighted one dentist's kindness as follows:

> *"The dentist was nice. I felt good in the room because the dentist spoke with me in Spanish too, and was very kind."*

4.2.3 Feelings of discomfort and perceived pain as a reason to avoid follow-up visits

While most children said they appreciated their dental visit and were willing to return, some were less eager to return in the future due to discomfort or pain they had experienced during treatment. For instance, an eight-year-old girl reported her discontent with a specific dental procedure:

> "*The dentist put something in my mouth for picture and asked me to crush it. It hurt and it was hard for me because my mouth, it's little. I don't want to take the picture again."*

Even among children reporting positive experiences, some expressed their fear of feeling pain during the next dental visit, such as this six-year-old girl:

“They did something that will hurt me. They didn’t hurt me today. But next time when they will remove ‘caries’ from my teeth, it will hurt. Today, they just viewed my teeth and washed them. I saw another boy today there in the room. They were removing his caries and it hurt him.”

4.3 Summary of the results

My results show that participants linked oral health to dental appearance (e.g., teeth color and alignment) and symptoms such as tooth pain and halitosis. They also associated oral health with preventive care, including diet, oral hygiene, and dental visits. When describing their experience at the dental clinic, most children replied positively and were willing to visit the dentist again. However, discomfort during dental treatment and fear of pain during dental procedures made some children apprehensive of follow-up visits.

5. Results (parent participants)

Description of the participants

Eleven refugeed parents were interviewed. The interviews were conducted in English and Punjabi,and lasted between 30–40 minutes. The sociodemographic data from these participants are listed in Table 2.

Table 2: Sociodemographic data of the parent participants

Characteristics	Categories	Number of participants
Gender	Male	5
	Female	6
Country of origin	India	4
	Jamaica	1
	Mexico	1
	Egypt	1
	Not disclosed	4
Language of the interview	English	7
	Punjabi	4
Number of children	Two	7
	Three	3
	Four	1
Time in Canada	< 1 year	2
	1–2 years	8
	> 2 years	1

The results are divided into three main categories based on the research question regarding the parents' understanding of oral health and their experiences before and after accessing oral health care for their children.

5.1 Understanding of oral health

When asked to define oral health, parents connected it with their mouth, teeth, dental pain, oral health care habits, and dentist visits. For example, a father of two children who arrived in Canada a year and a half ago said:

> *"By oral health, I understand that it is related to our teeth, gums, and other parts of the mouth. Another important thing that I consider regarding the good oral health of a person is having good teeth. According to me, if your teeth are clean, or healthy, and you don't have any problem like pain in your teeth while eating, then I believe that the person is having good oral health."*

Some parents associated oral health with oral health care habits, such as brushing, flossing, and visiting the dentist. For instance, a father who had recently arrived in Canada shared these thoughts:

> *"My understanding of oral health is that I think it is everything that has something to do with the teeth, tongue, and everything that is in the mouth. Oral health also includes flossing teeth, brushing teeth, and even going to the dentist."*

5.1.1 How parents value oral health

Parents valued the importance of oral health for a variety of reasons. Most parents connected good oral health with overall health and felt that maintaining good

oral health was a contributing factor to achieving good overall health. In sharing his thoughts on the relevance of maintaining good oral health, a participant stated that oral health was essential because the mouth is a gateway to the body. He added:

> *"It is as important for a person as eating food daily. It is very important. The mouth is a part, a pathway to our body. I think that your good or bad overall health depends upon your mouth. For example, if a person drinks contaminated water or eats contaminated food, he can get sick. So, your overall health depends upon your mouth, and mouth is directly related to your oral health."*

Most participants reported that maintaining good oral health was essential to avoid physical discomfort. They shared several examples, such as the importance of improving and maintaining good oral health to avoid tooth decay and pain. Participants also considered factors such as increasing age, difficulty in chewing, eating, and speaking of importance to maintain good oral health. A father mentioned that taking care of oral health is highly relevant to relieving dental pain during dental visits, stating that:

> *"I often see that if people do not care for their oral health, after a certain age, some people then start experiencing oral health problems specifically related to their teeth. Then the people start experiencing problems while eating too. They also face difficulties while eating and chewing food. Then they even start experiencing pain in their teeth."*

Similarly, another parent mentioned:

> *"With increasing age, the oral health of a person becomes poor. In order to protect your teeth for a later stage of life, you should start caring for your oral health at an earlier stage. Teeth are very important for a person*

because you can't eat and speak properly without teeth. I have personally experienced this thing. My molars were not in good condition, I developed caries, then I started experiencing pain. I got them extracted and now, as a result, I can't eat properly as I did before with those teeth present."

5.2 Barriers parents experienced prior to finding oral health care for their children

Before finding oral health care for their children, parents faced several barriers. Barriers included their own lack of knowledge about the health coverage plan (IFHP) they were eligible for in Canada, the limited availability of information about IFHP, their lack of knowledge about local clinics that provide health and oral health care to refugeed persons, and limited sources of information about navigating health and oral health care services once in Canada. These points are further detailed below.

5.2.1 Lack of knowledge about health coverage and accessible clinics

Lack of knowledge of oral health coverage is a major contributing factor to accessing oral health care and a challenge the parents faced in accessing oral health care for their children. Most reported not knowing anything about the IFHP and that they knew little about how or where to seek information regarding accessing oral health care for their children. One father summed this up as follows:

"I don't know anything about the health and dental coverage we are having. I am even not sure that for how long will we receive free dental treatment, I mean, for how long all these services will be covered. If the government or any other institution could provide the information to us when we enter Canada, it would be extremely helpful for us. Even if they

can just inform us that these are the type of medical and dental services that we can avail free of cost and where we can go to get treatment, that would be extremely helpful."

Parents also mentioned that limited availability of information regarding accessing oral health care made their search for care difficult. They experienced a lack of information, feeling uninformed about the IFHP or any benefits their children were entitled to. The parents were worried about their children experiencing pain, yet were unable to find care. Notably, one participant said:

"My children were in need to see the dentist, but I was not aware that we could get free treatment, and I was not aware which clinic to visit. It was obviously difficult because you don't know what to do. Your children are having pain and you don't know what to do. So many people don't know where to go, and that they offer free treatment. That's because nobody inform us when we arrive in Canada. Anyone with the welfare paper surely knows that they are covered, but they don't tell us that where can we receive treatment and what type of treatment we can get. I suggest that when people come to Canada they should inform them that what are they entitled to receive as refugees."

5.2.2 Sources of information for accessing oral health care

While sharing their experiences regarding available information, parents also shared how they attempted to find information regarding their access to care and how they ultimately found a way to access oral health care services for their children. A father reported that he tried to find information on the internet:

"Knowledge is an issue. I was not told by anyone here in Canada that which institution I can visit. I had to search for this institution on the Internet on my own. Even on the internet, I didn't find the right number for this institution. I mean, I called the wrong person. Probably, if someone had informed me that which institution refugees should visit, and what is the contact number of that institution, I wouldn't have waited for so long."

Parents mentioned that they only found access when helped by others, such as school teachers, general physicians, and friends. For example, a father reported he was unaware of any clinic that could provide oral health care to his son, so he just went for a regular health check-up, where the doctor told him that his son required dental treatment. The doctor then informed him that his son was entitled to free dental treatment at the MCH clinic. Similarly, a mother of two children encountered a similar situation:

"We were helpless. We didn't have enough money to take him to the doctor straight away and I didn't know where to take him for free treatment. I was not aware of anything, so I just started talking to people thinking that someone might help us. And it finally happened. Three months ago, when I gave birth to my second son, I was having a random chat with the doctor. The doctor who took care of me informed me that refugee children are eligible for free dental treatment. I told her that I need treatment for my elder son. Then she called Montreal Children's Hospital and booked an appointment for me."

Given the lack of information, three participants mentioned that, as a last resort, they called an ambulance as they would for any medical emergency. For them, the

emergency room seemed to be their only option to obtain care for their children. One father of two children said:

> *"I was not sure what to do specifically. But I knew that we can call an ambulance in case of any emergency situation. I was not sure how the medical treatment goes here in Canada. When we had trouble, I called an ambulance for the first time. The ambulance took us to the hospital, but now the clinic has my contact number. They call me now to tell me that it's time for the regular check-up of my son and you should now bring him to the hospital."*

5.3 Experiences of the parents after finding oral health care for their children

The next section describes parents' experiences after they learned about the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital.

5.3.1 Overcoming challenges

After learning about the MCH clinic, parents still experienced barriers to their children's oral health care. For example, language was a barrier when contacting the clinic; almost 40% of these parents were not fluent in English or French. Relating this issue to her situation, a mother described her difficulties communicating with the receptionist when booking the appointment. To overcome this challenge, she brought a neighbor with more linguistic abilities to the appointment to ensure better communication with the staff. In response to such linguistic constraints, another mother reported:

"I think interpreters should be available in these institutions too. Although I speak and understand a little bit of English, still sometimes I face a problem to make myself clear. And not everyone speaks English or French very well. So I think there must be interpreters present in such institutions where they deal with refugees."

For some parents, the institution's location was a barrier as they had to travel long distances, some by car and others by public transportation. They were motivated to overcome these challenges, understanding the importance of oral health. Regarding this scenario, a mother of four children shared:

"I live far from here. To come here, I need to take a bus and then change two metro trains. Then I have to walk for 5 to 8 minutes to reach here. It is an issue because we can't go to any other clinic which is there in our area. Coming here from a long distance, like I do, is very difficult. But then, teeth of my children are much more important for me."

Participants mentioned that the clinic seemed to have a policy that did not tolerate tardiness. When public transportation was slow, there was heavy traffic, or a lack of parking causing them to be late for the appointment, they would often arrive only to be told their appointment was canceled. A father described challenges finding parking at the clinic's designated parking spaces, which were limited and often occupied. On one trip to the clinic, he had to seek parking elsewhere and, as a result, arrived late for his son's appointment, which was canceled at a result. He said that he faced the same parking issues on the day of the interview as he could not find a parking spot at the clinic. He dropped his son at the clinic door and then went to find a parking spot.

Participants suggested resolving these issues by having similar institutions in more localities of Montreal. For example, a father said:

> *"Whenever we come here, it almost takes us about half an hour to reach the hospital depending upon the traffic conditions. Sometimes, I get stressed because I know that if I am late, even if it is for 5 to 10 minutes, because they will cancel the appointment. I just think that it would be helpful for us if there were more institutions like this."*

5.3.2 Awaiting care

Some participants commented on what they considered a long waiting time between follow-up appointments; this lengthy wait delayed resolving their children's oral health care problems. A mother expressed that she waited for over a month to confirm her child's first appointment; similarly, she felt the time between the two follow-up appointments was excessive. A father disclosed similar frustrations:

> "*I got appointment for my kid more than a month after calling the hospital. Now after the appointment, we have to wait again for long before the next appointment. This delays treatment and the problem will continue until it is fully resolved after a few appointments. There must be less waiting time before appointments to resolve the problems as soon as possible.*"

5.3.3 Financial challenges with dental coverage

Some parents expressed frustration with the partial dental coverage provided by the IFHP. As a result, they could not receive all the desired treatment for their children free of cost. They also mentioned that due to their limited financial resources,

they could not augment the desired treatment by paying out-of-pocket. This situation led one father to question how the clinic cares for refugee people:

> *"I think they are trying to refuse us the treatment that we need. When we came here last time, they provided me with visiting cards of some private clinics. They told me that if you can afford private treatment, please visit these clinics and seek treatment for your daughter. If we need to visit a private clinic, then why are we coming here for treatment? Why they say that they are treating refugees here and that they are eligible for free treatment?"*

5.3.4 Positive experiences with quality care

Overall, the parents appreciated the quality of care their children received at MCH, and the participants felt satisfied with the polite behavior of the dental staff. Parents felt satisfied with the ongoing treatment and guidance about future treatments. One mother reported that she liked coming to the clinic and felt the staff were helpful, listened to her, and made things easy. Another parent stated that:

> *"I feel happy and like coming here because it's good. The treatment is free, and they take good care of your child. The staff here is very polite and generous. They inform you with the treatment they provide and about the treatment that is needed in future for your child. They also guide you how to take good care of the oral health of your child."*

Some participants mentioned the minimal waiting time on the day of the appointment. For instance, a father of two children said he liked that after arriving at the clinic, the waiting time to see the dentist was minimal, and the clinic staff immediately took his child to the clinic room for treatment.

Parents compared the oral health care they received in their home country with the care they received at the clinic. They said the facility and equipment were well kept and better than in their home country and appreciated the clean and quiet environment. While comparing the cleanliness at the clinic to the ones in their home country, a father said that anyone could get sick just by going to the government hospital in his home country. Their positivity towards the institution suggested that the parents were satisfied with the care their children received. For example, a mother said:

> *"The people who provide dental service in my country are not like people here in Canada. In Canada, they have good facilities, but in my country they just have a mirror, to check. Here in Canada, they provide good treatment. When I brought my first daughter here for treatment, I saw that they provided good treatment, so I decided to bring my other two daughters here for treatment."*

5.4 Summary of results

The analysis revealed that the parents had a good understanding of oral health and its importance, and were motivated to support their children's oral health. Their lack of knowledge about oral health coverage and limited available information about finding care were experienced as major barriers to finding care, as were their financial constraints, made worse by the partial coverage provided through the IFHP. The obstacles parents faced at the clinic included language barriers, the institution's location, and the clinic's policy of canceling appointments when parents ran late. Nevertheless, parents seemed determined to overcome these obstacles to access oral health care services for their children, and most of them felt satisfied with the care they

received at the clinic and appreciated the kind behavior of the staff. Further, they shared positive thoughts about the equipment and services at the clinic compared to their home country and appreciated the clean and pleasant environment.

6. Discussion

This study sought to shed new light on the oral health perceptions of refugeed children in Montreal and learn about their first-hand experiences in receiving oral health care. This study also explored the experiences of refugeed parents and the barriers they faced while accessing oral health care for their children. This chapter will discuss the results of this study in relation to the available literature regarding the oral health of refugeed persons, oral health care experiences of refugeed children, and their parents' experiences before and after finding access to care for them.

6.1 Children's reflections on their mouths

To our knowledge, this is the first study to include the oral health care experiences of refugeed children and their perceptions about their oral health. Children are not often involved in dental research as active participants, and so their perspectives are not considered (73, 74, 92); while their involvement is increasing (72), it is not yet standard in dental research. Critical literature argues that children's voices about their own experiences must be purposely incorporated into research to improve children's healthcare outcomes (72-74, 93). Thus, this study was devised to explore refugeed children's understanding of their oral health and learn from their experiences at the dental clinic; we hope our results can contribute to helping improve their oral health care outcomes.

Evidence suggests that children start developing the ability to reflect on the self and compare their physical appearance and personal features with other children at about six years of age (94-96). Our findings concur; the children who participated possessed knowledge about oral health and were conscious of the aesthetics and health of their mouths. Almost all children participants described the appearance of

their mouths and teeth as good or bad and provided reasons for their responses. They also compared the appearance of their teeth and mouths with their friends' teeth and mouths.

Furthermore, our findings show that our young participants had suggestions for improving their oral health, including oral health practices such as visiting the dentist to seek oral health care and exercising good oral health measures, such as brushing regularly. Some studies (clinical and proxy reports) suggest that refugeed children experience multiple oral health-related problems (5). Although we did not find any studies with self-reported data from refugeed children, the available studies with refugeed adults have reported that they perceive their oral health to be poor (7, 97). In our findings, most child participants reported problems with their teeth or mouths and perceived their oral health to be poor. Clinical studies also suggest that children from underprivileged families in Canada — including refugeed children — experience many oral health-related problems (16, 35, 67, 69, 98). Although our oral health status findings are self-reported and cannot be directly compared with these clinical studies, our results indicate similar findings.

6.2 Experiences of children at the dental clinic

We could not find any studies focusing on the impact of the relationship between refugeed children and their oral health care providers on care outcomes. Studies with children, in general, demonstrate that children believe having a good relationship with their dentist is important (92). Moreover, a Canadian study by Mostajer Haqiqi et al. suggested that parents believe a good relationship between a dentist and a child is important because the children will take recommendations by the dentist more seriously and, therefore, may remain more attentive to their oral health

(62). Our results corroborate these studies as our child participants understood the importance of visiting the dentist. Those who developed a good relationship with their dentist expressed willingness to visit the dentist again and linked their visit to the dental clinic with good oral health.

The literature suggests that patients who are satisfied with their treatment tend to follow their physician's instructions and recommendations (99-101). Moreover, some studies have shown that patients are most satisfied when the treatment is received in comfort and they feel respected (62, 98, 102); we could not locate similar literature specifically on children. Notably, many of the children in our study shared positive experiences and felt motivated to visit the dentist again due to factors such as dentists' friendly behavior, being treated kindly and respectfully at the clinic, and receiving rewards such as stickers.

Our child participants reported a negative experience with the dentists if they experienced pain during treatment (103). Studies have also suggested that children can develop fears of dental treatment because of anticipated or experienced pain and discomfort (103, 104). Our findings are similar to these studies as the fear of pain made two child participants respond negatively and say they did not want to visit the dental clinic again as they might experience pain during their follow-up visit.

6.3 Oral health understanding of the parents

Studies in Canada with refugeed persons show that they were aware of the importance of oral health and the effects of poor oral health on general health (7, 47), and our findings support these studies. The parent participants understood the importance of oral health and its implications, with many stating that good oral health

is important to avoid complications (e.g., pain and dental caries) and other discomforts (e.g., difficulty chewing, eating, and speaking).

Studies suggest that parents' cultural knowledge about diet may affect their children's oral health and that some parents do not think children's primary teeth are important, instead believing dental caries are simply 'childhood problems' (105, 106). Interestingly, this was not the case with our participants. Parents in our study knew about oral health and its relevance. They did not ignore their children's oral health or their primary teeth; in contrast, they showed interest and expressed their concerns by giving examples from their personal experiences about oral health. They linked oral health with teeth, mouth, and overall body health. Furthermore, they were aware that oral health conditions increase with age, so they advocated for treating their child's oral health problems early.

6.4 Experiences of parents prior to finding oral health care for their children

A Canadian study involving refugeed adults suggested that when confronting the health care and dental care systems in Canada, compared to the systems in their countries of origin, many obstacles can arise, including difficulty in accessing oral health care services (14). Another study suggested that refugeed persons in Canada may lack awareness about their oral health care resources (44). Our participants faced barriers before and after finding access to oral health care for their children. Our parent participants expressed helplessness and frustration when speaking about their difficulties before finally attending the MCH clinic. Our participants described barriers, including lack of knowledge and lack of available information about the healthcare programs in Canada. Once they identified the MCH clinic, they faced other challenges,

including the institution's location, language barriers, long wait times before follow-up appointments, and partial coverage of treatment expenses.

A Canadian study suggested that social workers and community leaders actively helped some newly-arrived refugeed persons find access to oral health care (14). Our participants did not mention help from such liaison workers. Our findings suggest that the lack of knowledge about the available healthcare programs was a major issue faced by the parents, as was the lack of available information about navigating the healthcare system in Montreal. Most parents conveyed that no agency helped them find access to oral health care and that health authorities or government officials provided no direct information regarding health care coverage or institutions to visit upon entering Canada. While some found access to oral health care for their children after gaining information from their friends, neighbors, general health practitioners, or school teachers, others had to consider emergency room services as a last resort, a finding backed by another Canadian study (62).

6.5 Experiences of the parents after finding oral health care for their children

Communication and spoken language are two essential components of dental care (14). A communication gap is a prevalent issue affecting the connection between dentists and refugeed persons (71), and language is a commonly reported barrier for refugeed persons accessing health care services in Canada (43, 44, 63, 107). Similar to several studies (43, 63, 71, 107), our findings suggest that a language barrier is a major concern for refugeed families who are not fluent in French or English in Montreal. The participants, for instance, had difficulty communicating with the staff to book an

appointment and discuss treatment. As a result, some families brought their own interpreters to facilitate communication at the clinic.

Research suggests that the location of the care institution and transportation can be barriers for refugeed persons, making access to care difficult (45, 108). Such barriers can lead to patients arriving late or missing appointments (45). Moreover, our results suggest that the institution's location was a barrier for participants who had to commute long distances, especially those experiencing difficult weather conditions and using public transportation. The participants who used personal vehicles for commuting also faced issues with transportation due to limited parking options. As a result of these hurdles, some participants missed their appointments as the clinic canceled their appointments due to their tardiness.

Refugeed persons often have limited finances when arriving in Canada (5), making accessing oral health care more difficult if they cannot afford private care. Studies, including one from Quebec, have demonstrated that children from financially unstable families suffer more from poor oral health (62, 98, 109). These findings relate to our data as our participants reported they could not afford the necessary treatment (e.g., orthodontic treatment for their children) because the IFHP did not cover it.

Studies from Montreal suggest that underprivileged persons often find it difficult to develop a good relationship with their caregivers as they perceive that clinicians do not understand them; as a result, they feel neglected and stigmatized (83, 110, 111). This was not the case with our participants, who, on the contrary, felt valued at the MCH dental clinic. Most child and parent participants reported a good relationship with the dentists, and parents also mentioned having good relationships with the dental staff. Despite facing various obstacles after finding care, the parent participants shared many positive experiences. Other authors have suggested that the comfort of the child

receiving treatment, staff's behavior with persons receiving care, waiting time, and time required to complete the treatment are important factors that affect patients' satisfaction (62, 98, 102). Similarly, our participants appreciated the helpful and generous behavior of the staff. Evidence has also revealed that people seek a good and trustworthy relationship with clinicians (112); a good connection with healthcare providers is pivotal to improving the utilization of oral health care services (84, 113). Our study supports these statements: the polite behavior of the dentists and staff fortified the trust of our participants, and consequently, they felt motivated to return to the clinic for future oral treatments for their children. The participants also appreciated the quiet and clean environment of the clinic and praised the equipment and services of the facility.

7. Strengths and limitations of the study

To the best of my knowledge, this is the first study in Canada to directly include the voices of refugeed children in oral health research. The results provide unique insights into refugeed children's oral health understandings and behaviors as well as their oral health care-related experiences. Furthermore, this study provided a platform for refugeed children and their parents to share their oral health care perceptions and experiences in the host country.

Despite the promising data, several important limitations stand out. First, only participants who could communicate in English, Hindi, and Punjabi were recruited. Interviews with seven families were conducted in English; however, of those, only 2 participant families spoke English as their first language; therefore, some of these participants may not have been able to fully express their thoughts and experiences. As I, the interviewer, was unable to communicate in French and we did not have the resources to hire additional team members, two willing families who only spoke French fluently could not participate. Parents from four families refused to participate, stating that they felt their participation could affect their legal status in Canada; they mentioned that lawyers had advised them not to disclose any information. Two other mothers stated they were interested but first wanted to consult with their husbands; they were unable to contact their husbands during the visit and so had to be excluded.

The second limitation is that we only recruited participants from the Immigrant and Refugee Pediatric Dental clinic at the Montreal Children's Hospital. To the best of our knowledge, this clinic is the only institution that provides free comprehensive oral healthcare to refugeed children in Montreal. As a result, our data may not be transferable to refugeed families seeking care in other settings such as private dental clinics, or to families who have not sought care.

The third limitation is regarding the interview setting — a dental clinic. Social desirability may have affected the participants' responses; they may have responded more positively to the questions related to oral health, referring to it as an important aspect of their life and daily routine, given they were sitting in a positive dental environment. To mitigate this possibility, I invited participants to express themselves as freely as possible during the interview process and endeavored not to convey a bias towards oral health care. Importantly, participants did offer some negative views and experiences regardless of the clinic environment.

8. Knowledge translation and future directions

Our future intention is to share the results of our study with the dentists and dental staff of the Montreal Children's Hospital. We will also share our results with local community organizations. Our goal is also to provide information sessions to newly-arrived refugeed families regarding the oral health care plans they are entitled to in Canada.

We have already presented results at the following events: McGill University Faculty of Dentistry Annual Research Day (2021), the Division of Dentistry Research Day of Montreal Children's Hospital (2021), and the annual North American Refugee Health Conference (2021). Moving forward, we intend to submit an abstract to the International Association for Dental Research conference, and a manuscript to a scientific journal for further knowledge dissemination.

Our study mainly focuses on the perceptions and dental care experiences of the refugeed children and their parents in accessing oral health care. While most participants praised the arrangements of the institution and dentists, some shared negative experiences. While we do not have the perspectives of the dentists and the institution staff regarding participants' experiences, our team is currently conducting a study at the clinic to explore the perspectives of the dentists and other staff involved in providing oral health care to refugeed children. This study will allow us to further elaborate on some of the barriers faced by refugeed people and work with the clinic to reduce them.

During the interviews, some parents explained that the school teachers informed them about their children's oral health and suggested they consult the Immigrant and Refugee Pediatric Dental Clinic at the Montreal Children's Hospital. Given this context, it is also highly relevant to assess the perspectives of the school

teachers working with these children and how they can best support refugeed parents by supplementing and influencing their oral health knowledge about their children. Our team has also begun such a study.

Similar studies should also be conducted in other geographical regions of Canada, especially in the other provinces that accept many refugeed people (e.g., Ontario). This should be done to compare and better understand the oral experiences of refugeed children and their parents in those provinces with an overall goal of reducing their oral health disparities and difficulties.

9. Conclusion

With increasing numbers of refugeed persons globally, and Canada being one of the main host countries to accept refugeed persons (5), it is of the utmost importance to explore their access to health care and service utilization once in Canada. Furthermore, it is known that refugeed children in Canada have poor oral health (16, 36, 51, 71), yet little is known about their oral health care experiences and access to oral health care. With this study, we endeavored to shed some light on the perspectives of refugeed children regarding their oral health care experiences in Canada and their parents' perspectives about accessing care before and during their search for oral health care for their children.

The findings from this study suggest that despite their young age, refugeed children had a good understanding of oral health. They were concerned about how the state of their mouth affected their appearance and were aware of physical signs and symptoms of oral health, such as tooth pain and halitosis. The children were aware of and had a basic understanding of the procedures carried out during their dental visit. Their positive experiences at the dental clinic, including the polite behavior of the dentists and receiving rewards after treatment, contributed to their willingness to return for follow-up visits. Such positive experiences could be promoted further to increase the willingness of refugeed children to visit a dentist, thereby improving their oral health.

Similarly, the refugeed parents in this study were knowledgeable about oral health and valued its importance. The main barriers parents experienced before finding a dentist for their children included their lack of knowledge about oral health coverage, navigating oral health care pathways in Montreal, and limited information about local institutions providing care for refugeed children. These barriers hindered

their access to oral health care. Addressing these barriers, such as better informing refugeed families about oral health benefits once they arrive in Canada, and providing more information about the location of tailored services, could help increase their access to oral health care. Barriers that refugeed parents faced after finding dental care services for their children included the limited coverage of dental treatments under the IFHP, language barriers, and the challenge of arriving at appointments on time (due to problems related to public transportation or parking) given the clinic's policy of canceled appointments when parents arrive late.

Further research is needed to understand the perspectives of health care workers providing oral health care to refugeed children. However, the findings of this study are already useful for oral health care providers and institutions providing care to refugeed persons. These findings demonstrate the difficulties faced by refugeed families and their positive experiences at one local dental office. Access to oral health care for refugeed families can be improved by reducing the barriers they face and motivating them to seek oral health care by promoting their positive experiences. In addition, these data also provide important insights for government and community organizations about the difficulties refugeed persons face while accessing oral health information in Montreal. Enhancing access to information about the host country's healthcare system, dental care benefits, and designated healthcare institutions providing dental care after arrival could facilitate refugeed families' access to oral health care.

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11. Appendices

Appendix A: Advertisement poster (English)

Appendix B: Advertisement poster (French)

Appendix C: Consent form (English)

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INFORMATION AND CONSENT FORM

Refugee Children (aged 6-12 years), and their parents

Research Study Title:	Oral health experiences of refugee children, and their parents' perspectives on access to care.
Protocol number:	2020-5874
Researcher responsible for the research study:	Manav Preet Singh Saini
Co-Investigator(s)/sites:	Dr. Beatriz Ferraz Dos Santos Dr. Mary Ellen Macdonald Dr. Christophe Bedos
Sponsor:	None

INTRODUCTION

We are inviting you to take part in this research study because you receive dental care in our clinic.

However, before you accept to take part in this study and sign this information and consent form, please take the time to read, understand and carefully examine the following information. You may also want to discuss this study with your family doctor, a family member or a close friend.

We invite you to speak to the researcher responsible for this study (“the researcher”) or to other members of the research team and ask them any questions you may have about this study. Please also ask a member of the research team about any parts of this consent form you do not understand.

In this research information and consent form, “you” means you and/or your child.

BACKGROUND

After arrival in Canada, you might have faced some difficulties in finding a place to take care of your teeth. This can cause delays in receiving treatment for oral health needs and may ultimately result in poor oral health outcomes for children, and a stressful situation for parents in finding the access to oral health care services. With this study, we want to know more about your oral health related experiences in Canada to increase the little knowledge we have about this topic, with an overall aim to contribute towards your oral health.

PURPOSE OF THE RESEARCH STUDY

The purpose of this study is to explore how refugee children in Montreal understand oral health and how they experience oral care. Also, we want to understand in depth about the experiences of refugee parents’ accessing oral health care for their children. For this research study, we will recruit refugee children (aged 6-12 years), and their parents. As it is a qualitative study, the sample will be determined by saturation of the data. We estimate 10 children and their parents.

DESCRIPTION OF THE RESEARCH PROCEDURES

This research study will take place at The Division of Dentistry, Montreal Children's Hospital.

1. Duration and number of visits

Your participation in this research study will include one visit of 60 minutes.

2. Overview of study participation

For this study, we will ask you to participate in an interview. During the interview, we will ask you questions regarding your oral health experiences before and after your arrival in Canada. Other information, such as your name, sex, date of birth and ethnic origin may also be collected during the interview.

3. Study procedures

During your participation in this research study, you will participate in the following procedures:

Interview: Face-to-face interview, that is expected to last 20 minutes for your child and 40 minutes for you. You will be interviewed separately. However, before the interview, we will ask your child about his or her choice for getting interviewed in your presence or your absence, and we will follow accordingly. You will be interviewed during the time your child receives treatment, and your child will be interviewed once his or her treatment regime is complete.

Participant observation: Participants will be observed in the clinic while they wait for the treatment. The sole purpose of participant observation is to get familiar with the environment of the dental clinic, and to get acquainted with the participants. However, no data will be collected prior to the interview.

BENEFITS ASSOCIATED WITH THE RESEARCH STUDY

You may or may not personally benefit from your participation in this research project. There is no direct benefit to you for taking part in this study. However, we hope that with this study, we will better understand the oral health related experiences and perspectives of refugee children and their parents.

RISKS ASSOCIATED WITH THE RESEARCH STUDY

We do not foresee any risks associated with this study. We guarantee you the strictest confidentiality. You will also have all rights to discontinue the interview and withdraw from the study without any consequences. If certain questions put you ill at ease, you will also have the right not to answer it. In any case, you will undergo no damage.

VOLUNTARY PARTICIPATION AND THE RIGHT TO WITHDRAW

Your participation in this study is voluntary. Therefore, you may refuse to participate. You may also withdraw from the project at any time, without giving any reason, by informing a member of the study team. Your decision not to participate in the study, or to withdraw from it, will have no impact on the quality of care and services to which you are otherwise entitled.

If you withdraw or are withdrawn from the study, you may also request that the data already collected about you be removed from the study. If you request that your data be removed, and the information already collected about you can be identified as yours it will be destroyed.

CONFIDENTIALITY

During your participation in this study, the researcher and his/her team will collect and record information about you. They will only collect information necessary for the study.

The following information will be collected: information about your identity, concerning your past and present state of health, your lifestyle and your experiences about the health care services. Your research file could also contain other information, such as your name, sex, date of birth and ethnic origin.

All the information collected during the research project will remain confidential to the extent provided by law. You will only be identified by a code number. The key to the code linking your name to your study participant number will be kept by the researcher.

All audio-recordings will be transcribed (your words will be written down) in a de-identified fashion (i.e. your name will not appear in the transcripts). The audio-recordings will then be destroyed. It is possible that direct quotes of what you said will be presented in publications and/or conferences. However, precautions will be taken to ensure that it will not be possible to identify you.

The study data will be stored for 7 years by the researcher responsible for the study.

The data may be published or shared during scientific meetings; however, precautions will be taken to ensure that it will not be possible to identify you.

FUNDING OF THE RESEARCH PROJECT

The researcher have received funding from supervisor's discretionary funds to conduct this research project.

CONFLICT OF INTERESTS

The researchers have no conflict of interest to declare.

COMPENSATION

In recognition of your participation in this study, the parent participants will be provided with a $20 gift card. Child participants will be provided with a toy and dental care products.

SHARING STUDY RESULTS

If you wish, you will be able to communicate with the research team in order to obtain information regarding the progress of the procedures or results of the study. The results will be made available to you at the end of the study. A presentation based upon the results of this study will be presented at the Montreal Children's Hospital and the McGill University Faculty of Dentistry. Results from this study will be presented at conferences and published in journals.

SHOULD YOU SUFFER ANY HARM

Should you suffer harm of any kind following any procedure related to the research study, you will receive the appropriate care and services required by your state of health.

By agreeing to participate in this research project, you are not waiving any of your legal rights nor discharging the researcher, the sponsor or the institution, of their civil and professional responsibilities.

CONTACT INFORMATION

If you have questions or if you have a problem you think may be related to your participation in this research study, or if you would like to withdraw, you may

communicate with the researcher or with someone on the research team at the following number:

Dr. Beatriz Ferraz dos Santos

Division of Dentistry,

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Montreal, Quebec H3A 1G1

Tel: (438) 622-8554

E-mail: manav.saini@mail.mcgill.ca

For any question concerning your rights as a research participant taking part in this study, or if you have comments, or wish to file a complaint, you may communicate with:

The Patient Ombudsman of the Montreal Children's Hospital at the following phone number: (514) 934-1934, ext 22223

OVERVIEW OF ETHICAL ASPECTS OF THE RESEARCH

The McGill University Health Centre Research Ethics Board reviewed this research and is responsible for monitoring the study.

Research Study Title: Oral health experiences of refugee children, and their parents' perspectives on access to care.

SIGNATURES

Signature of the participant

I have reviewed the information and consent form. Both the research study and the information and consent form were explained to me. My questions were answered, and I was given sufficient time to make a decision. After reflection, I consent to participate in this research study in accordance with the conditions stated above.

1) I authorize a member of the research study to contact me to check the transcript of what I said.

   Yes ☐ No ☐

2) I wish to receive a copy of the study results by email.

   Yes ☐ No ☐ If yes, please provide contact information:

_____

3) I authorize a member of the research study to contact me in the future to ask if I am interested in participating in other research.

   Yes ☐ No ☐ If yes, please provide contact information:

_____

Name of participant Signature

Date

Signature of the person obtaining consent

I have explained the research study and the terms of this information and consent form to the research participant, and I answered all his/her questions.

Name of the person obtaining consent Signature Date

Appendix D: Consent form (French)

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FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

Enfants réfugiés (âgés de 6 à 12 ans) et leurs parents

Titre de l'étude de recherche:	Les expériences de santé bucco-dentaire des enfants réfugiés et le point de vue de leurs parents sur l'accès aux soins.
Numéro de protocole:	2020-5874
Chercheur responsable de l'étude de recherche:	Manav Preet Singh Saini
Cochercheur (s) / sites:	Dr. Beatriz Ferraz Dos Santos Dr. Mary Ellen Macdonald Dr. Christophe Bedos
Sponsor:	Aucun

INTRODUCTION

Nous vous invitons à participer à cette étude car vous recevez des soins dentaires dans notre clinique.

Toutefois, avant d'accepter de participer à cette étude et de signer ce formulaire d'information et de consentement, veuillez prendre le temps de lire, de comprendre et d'examiner attentivement les informations suivantes. Vous pouvez également discuter

de cette étude avec votre médecin de famille, un membre de votre famille ou un ami proche.

Nous vous invitons à parler au chercheur responsable de cette étude («le chercheur») ou à d'autres membres de l'équipe de recherche et à leur poser toutes les questions que vous pourriez avoir sur cette étude. Veuillez également demander à un membre de l'équipe de recherche si vous ne comprenez pas certaines parties de ce formulaire de consentement.

Dans cette information de recherche et formulaire de consentement, «vous» signifie vous et / ou votre enfant.

CONTEXTE

Après votre arrivée au Canada, vous avez peut-être eu des difficultés à trouver un endroit pour prendre soin de vos dents. Cela peut entraîner des retards dans le traitement des problèmes de santé bucco-dentaire et, en fin de compte, des conséquences négatives pour la santé bucco-dentaire des enfants et une situation stressante pour les parents qui cherchent un accès aux services de soins bucco-dentaires. Avec cette étude, nous souhaitons en savoir plus sur vos expériences en matière de santé bucco-dentaire au Canada afin d'accroître nos connaissances sur ce sujet, avec comme but global de contribuer à votre santé bucco-dentaire.

BUT DE L'ÉTUDE DE RECHERCHE

Le but de cette étude est decomprendre comment les enfants réfugiés à Montréal perçoivent la santé bucco-dentaire et comment ils bénéficient de soins bucco-dentaires. Nous voulons également comprendre les expériences des parents réfugiés qui ont eu accès aux soins de santé bucco-dentaire pour leurs enfants.

Pour cette étude, nous allons recruter des enfants réfugiés (âgés de 6 à 12 ans) et leurs parents. S'agissant d'une étude qualitative, l'échantillon sera déterminé par la saturation des données. Nous estimons un total de 10 enfants et leurs parents.

DESCRIPTION DES PROCEDURES DE RECHERCHE

Cette étude de recherche aura lieu à la Division de médecine dentaire de l'Hôpital pour enfants de Montréal.

1. Durée et nombre de visites

Votre participation à cette étude de recherche comprendra une visite de 60 minutes.

2. Aperçu de la participation à l'étude

Pour cette étude, nous vous demanderons de participer à une interview. Au cours de l'entrevue, nous vous poserons des questions sur votre expérience de la santé bucco-dentaire avant et après votre arrivée au Canada. D'autres informations, telles que votre nom, votre sexe, votre date de naissance et votre origine ethnique porraient également être recueillies lors de l'entretien.

3. Procédures d'étude

Au cours de cette étude, vous participerez aux procédures suivantes:

Entretien: entretien personnel, qui devrait durer 20 minutes pour votre enfant et 40 minutes pour vous. Vous serez interviewés séparément. Cependant, avant l'interview, nous demanderons à votre enfant s'il préfère être interviewé en votre présence ou en votre absence, et nous respecterons son choix. Vous serez interrogé pendant le traitement de votre enfant. Votre enfant sera interrogé une fois son traitement terminé.

Observation des participants: Les participants seront observés à la clinique en attendant le traitement. L'observation des participants a pour seul objectif de se familiariser avec l'environnement de la clinique dentaire et de se familiariser avec eux. Cependant, aucune donnée ne sera collectée avant l'entretien.

AVANTAGES ASSOCIÉS À L'ÉTUDE DE LA RECHERCHE

Vous pourriez ou non bénéficier personnellement de votre participation à ce projet de recherche. Vous n'avez aucun avantage direct à participer à cette étude. Cependant, nous espérons qu'avec cette étude, nous comprendrons mieux les expériences et les perspectives relatives à la santé bucco-dentaire des enfants réfugiés et de leurs parents.

RISQUES ASSOCIÉS À L'ÉTUDE DE LA RECHERCHE

Nous ne prévoyons aucun risque associé à cette étude. Nous vous garantissons la plus stricte confidentialité. Vous aurez également le droit d'interrompre l'entretien et de vous retirer de l'étude sans aucune conséquence. Si certaines questions vous mettent mal à l'aise, vous aurez également le droit de ne pas y répondre. Dans tous les cas, vous ne subirez aucun dommage.

PARTICIPATION VOLONTAIRE ET DROIT DE RETRAIT

Votre participation à cette étude est volontaire. Par conséquent, vous pouvez refuser de participer. Vous pouvez également vous retirer du projet à tout moment, sans indiquer de motif, en informant un membre de l'équipe d'étude. Votre décision de ne pas participer à l'étude ou de vous en retirer n'aura aucune incidence sur la qualité des soins et des services auxquels vous avez par ailleurs droit.

Si vous vous retirez ou êtes retiré de l'étude, vous pouvez également demander que les données déjà collectées à votre sujet soient retirées de l'étude. Si vous demandez la suppression de vos données et que les informations déjà collectées à votre sujet peuvent être identifiées comme étant les vôtres, elles seront détruites.

CONFIDENTIALITÉ

Au cours de votre participation à cette étude, le chercheur et son équipe vont collecter et enregistrer des informations vous concernant. Ils ne collecteront que les informations nécessaires à l'étude.

Les informations suivantes seront collectées: des informations sur votre identité, sur votre état de santé passé et actuel, votre mode de vie et vos expériences en matière de services de santé. Votre dossier de recherche peut également contenir d'autres informations, telles que votre nom, votre sexe, votre date de naissance et votre origine ethnique.

Toutes les informations recueillies au cours du projet de recherche resteront confidentielles dans la mesure prévue par la loi. Vous ne serez identifié que par un numéro de code. La clé du code reliant votre nom au numéro de participant sera conservée par le chercheur.

Tous les enregistrements audio seront transcrits (vos mots seront écrits) de manière non identifiée (c'est-à-dire que votre nom n'apparaîtra pas dans les transcriptions). Les enregistrements audio seront alors détruits. Il est possible que des citations directes de ce que vous avez dit soient présentées dans des publications et / ou des conférences. Cependant, des précautions seront prises pour qu'il ne soit pas possible de vous identifier.

Les données de l'étude seront conservées pendant 7 ans par le chercheur

responsable de l'étude.

Les données peuvent être publiées ou partagées lors de réunions scientifiques; toutefois, des précautions seront prises pour qu'il ne soit pas possible de vous identifier.

FINANCEMENT DU PROJET DE RECHERCHE

Le chercheur a reçu un financement à partir de fonds discrétionnaires de ses superviseurs pour mener ce projet de recherche.

CONFLIT D'INTERÊTS

Les chercheurs n'ont aucun conflit d'intérêts à déclarer.

COMPENSATION

En reconnaissance de votre participation à cette étude, les parents participants recevront une carte-cadeau de 20 $. Les enfants participants recevront un jouet et des produits de soins dentaires.

PARTAGE DES RESULTATS DES ETUDES

Si vous le souhaitez, vous pourrez communiquer avec l'équipe de recherche afin d'obtenir des informations sur l'état d'avancement des procédures ou des résultats de l'étude. Les résultats vous seront communiqués à la fin de l'étude. Une présentation basée sur les résultats de cette étude sera présentée à l'Hôpital de Montréal pour enfants et à la Faculté de médecine dentaire de l'Université McGill. Les résultats de cette étude seront présentés lors de conférences et publiés dans des revues.

EN CAS DE PRÉJUDICE

Si vous subissez un préjudice quelconque après une procedure liée à l'étude, vous recevrez les soins et les services appropriés requis par votre état de santé.

En acceptant de participer à ce projet de recherche, vous ne renoncez à aucun de vos droits légaux et ne déchargez pas le chercheur, le sponsor ou l'institution de leurs responsabilités civiles et professionnelles.

INFORMATIONS DE CONTACT

Si vous avez des questions, des problèmes qui pourraient, selon vous, être liés à votre participation à la présente étude, ou si vous souhaitez vous retirer, vous pouvez contacter le chercheur ou un membre de l'équipe de recherche aux numéros suivants:

Dr. Beatriz Ferraz dos Santos

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1040 Avenue Atwater, Westmount

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Pour toute question concernant vos droits en tant que participant à cette étude, ou si vous avez des commentaires, ou si vous souhaitez déposer une plainte, vous pouvez communiquer avec:

L'ombudsman des patients de l'Hôpital pour enfants de Montréal au numéro de téléphone suivant:

(514) 934-1934, poste 22223

APERÇU DES ASPECTS ÉTHIQUES DE LA RECHERCHE

Le comité d'éthique de la recherche du Centre universitaire de santé McGill a examiné cette recherche et est chargé de son suivi.

SIGNATURES

Signature du participant

J'ai examiné les informations et le formulaire de consentement. L'étude et le formulaire d'information et de consentement m'ont été expliqués. On a répondu à mes questions et on m'a donné suffisamment de temps pour prendre une décision. Après réflexion, je consens à participer à cette étude de recherche conformément aux conditions énoncées ci-dessus.

J'autorise l'équipe à avoir accès à mon dossier médical aux fins de la présente étude.

1) J'autorise un membre de l'étude à me contacter pour vérifier la transcription de mes propos.

   Oui ☐ Non ☐

2) Je souhaite recevoir une copie des résultats de l'étude par courrier électronique.

   Oui ☐ Non ☐ Si oui, veuillez indiquer vos coordonnées:

_____

3) J'autorise un membre de l'étude à me contacter ultérieurement pour me demander si je suis intéressé à participer à d'autres recherches.

Oui ☐Non ☐ Si oui, veuillez indiquer vos coordonnées: _____

Nom du participant Signature Date

Signature de la personne qui obtient le consentement

J'ai expliqué l'étude et les termes de cette information et le formulaire de consentement au participant à la recherche, et j'ai répondu à toutes ses questions.

Nom de la personne qui obtient le consentement Signature

Date

_____

_____

Nom de la personne aidant en tant que traducteur Signature

Date

Appendix E: Semi-Structured Interview Guide for Children

The questions listed in this interview guide are provisional and they will be adapted during the interviews to capture the oral health and oral care related understanding and experiences of the refugee children. The language used will be the language spoken by the child and it will be adapted according to the child's age, level of education, perceived understanding and personal experiences.

The interviewer will introduce himself to the participant using his first name. The interviewer will then try to engage with the participant and maintain his/her attention. The interviewer will then ask participant to tell a little about themselves. In order to maintain attention of the child participant, the interviewer may engage in play with them. The interviewer will then explain to the participant that we are trying to understand your perspective regarding oral health. We want to know about what you think about your mouth and teeth and your experience regarding your appointment with the dentist.

Questions:

1. What do you think about your mouth?

    1(a). Is it good/bad or healthy/unhealthy?

2. What do you think about your teeth?

    2(a). Are they good/bad or clean/not clean or healthy/unhealthy?

3. Do you know friends who have healthy mouth and teeth? Friends who have unhealthy mouths and teeth?

    3(a). How can you say that they have a good/bad mouth or teeth?

    3(b). What prevents you and your friends from having a healthy mouth?

    3(b). What would help you to have a healthy mouth and teeth?

4. When do you go to see the dentist?

5. Who decides when it is time to go to the dentist?

5(a). You?

5(b). Your parents?

5(c). Your teacher?

6. What do you do at the dentist?

7. What happens when you go see the dentist?

7(a). How did you feel? What did you like or dislike?

7(b). How did you feel after your appointment?

7(c). What changes did you make after your appointment (brushing your teeth more/less, or eating sweets more/less often)?

8. Would you like to go to the dentist again, if needed?

6(a). What makes you say that you will or will not go again?

7. Is there anything else you would like to share with me?

Participants will be thanked for their answers and time.

Appendix F: Semi-structured Interview Guide for Parents

The proposed questions are provisional and will be adopted during the interviews to discern the thoughts of refugee parents about their experiences on accessing oral health care for their children.

A student researcher will introduce himself and will ask the participant to tell a little about themselves. The student researcher will explain the purpose of the project to the participant that this project aims to help us better understand the oral health experiences of refugeed children and their access to care.

Questions:

1. What do you understand by the term oral health?

    1(a). How would you define oral health?

    1(b). Is oral health important?

        -Why/why not?

2. When did you arrive in Canada?

3. How many children do you have and their ages?

4. What do you think about your children's' current state of oral health?

    4(a). How is it different from your home country?

5. What type of health coverage plan do you have for your children?

    5(a). When did you learn about this plan?

        -Before/after landing in Canada?

    5(b). How did you learn about this plan?

    5(c). Are your children covered under a similar type of plan?

6. What are the most common oral health concerns regarding your children that you have experienced since arriving in Canada?

    6(a). What did you do?

6(b). How you addressed them?

7. Have you ever encountered any dental care emergency situation for your children?

5(a). What did you do?

5(b). What type of service you availed? What was our experience of that particular situation?

8. How did you learn about this institution (MCH)?

8(a). Have you visited any other institution for oral care for your children before?

8(b) Do you like coming here for oral care services for your children?

-Why/why not?

9. What type of barriers have you experienced accessing oral health care for your children?

10. Based on your experience, what can be done to eliminate the barriers such as location, transportation, language?

11. Is there anything else that you would like to share with me about your experience in accessing oral health care for your children?

Participants will be thanked for their answers and time.

Appendix G: Interview review report form

Interview Report

Title of project:

Code/Interview # Interviewer: Date / time of interview:

Location of interview: Recruitment strategy:

Description of participant: [include pertinent information such as: gender, age, profession, relevance of participant to project]

1- How did the interview unfold?

   a. Was the participant on time? Were you?

   b. Were you alone with the participant; if not, who else was there and why? What was the impact of any additional people on the encounter?

   c. How did the participant seem to you: e.g., at ease? Nervous? Anxious? Tired? Engaged? Did this change in any way as the interview progressed?

   d. How would you characterize the atmosphere of the conversation; why/how?: e.g., a chat or a debate? Was there anger? Suspicion? Laughter?

2- During the interview, were there events that upset the flow? (e.g., phone calls, visitor arriving?) If yes, what happened and how did this affect the conversation?

3- Was there important information that was discussed when the audio-recorder was turned off? If yes, please describe.

4- Was the participant shy or intimidated by you? By the subject of the conversation? By the audio-recorder? How may this have affected the data?

5- Reflexivity: What strategies did you use to prompt the interviewee? How well did they work? Were there times when you felt the interview was going particularly well / not well? Why was this the case? What do you have in common with this interviewee? How might this have shaped the interaction?"

6- What were the main issues or important questions that came up during the interview?

7- Summarize the information in each of the main domains of the interview guide.

8- What new ideas or hypothesis or intuitions were suggested by this encounter?

9- Methodological reflections: What did this encounter teach you about the strengths and limits of this tool (interviewing)? What/how might you change in future encounters?

Appendix H: Example of the Analytic Process (children)

Table 3: Example of the Analytic process

Note: In this table, S = summary, A = analysis, I = interpretation

Category 1: Refugeed children's reflections on their mouths		
Themes	Sub-themes	Examples of codes
Children's reflections on their mouths	Dental appearance	S: Participant says that her teeth are clean because they are white. A: Seems to suggest that the participant is connecting the white colour of teeth with clean teeth. I: The white colouration of teeth makes the participant say that her teeth are clean, and she considers the white coloured teeth to be clean. S: Participant says that one of her friends has yellowish teeth, but his teeth are clean and good. She thinks that having slightly yellow teeth doesn't mean that the teeth are not healthy. A: Seems to suggest that the participant thinks that the yellow colour of teeth is not a factor related to the health of the teeth.

		I: It is interesting to see that the participant is normalizing the issue by referring to yellow teeth as clean.
	Absence or presence of physical signs and symptoms	S: The participant says that she has pain in some of her teeth. She also does not like the positioning of some of her teeth. She shares that she doesn't like the part of her mouth where those teeth become visible when she smile. She further shares that the rest of her mouth is good and healthy. A: Seems to suggest that the participant does not like the part of her mouth in which she does not like the position of her teeth, which becomes visible when she smiles. A2: Seems to suggest that the participant thinks that her mouth is not good because she has pain and she also does not like the position of some of her teeth. I: participant seems to relate good mouth to the pain and positioning of the teeth [when visible – this is important].
	Methods and practices for	S: Participant says that the people who don't visit the dentist regularly have bad teeth and if

	maintaining oral health	anyone with bad teeth visit the dentist, he/she may get good teeth. A: Seems to suggest that the participant thinks that not visiting the dentist regularly can result in bad teeth and if a person with bad teeth visits a dentist, he/she may get good teeth. I: The participant relates the lack of dental visits with the bad teeth of a person; and the ability of the dentist to help make good teeth
Category 2: Refugeed children's oral care experiences at the dental clinic in Montreal		
Themes	Sub-themes	Examples of codes
Experiences of children at the dental clinic	Awareness of the treatment procedures during visit at the dentist	S: Participant says that the dentist cleaned his teeth. They cleaned his teeth last time too. The dentist also took a 'photograph' of his teeth and told him to show them his teeth. A: Seems to suggest that the participant was aware and had some knowledge about the dental treatment procedure. I: It is interesting to see that the participant possessed some knowledge about the dental treatment procedure, and referred to radiographs as photographs (this became evident on further probing).

	Willingness for follow-up visits based upon positive experiences at dental clinic	S: The participants shares that she likes going to the dentist because she gets surprises such as a toothbrush, floss and sticker. She also likes sitting on the dental chair. A: Seems to suggest that getting surprises is an important factor for the participant to visit the dentist. A2: Suggests that the participant likes sitting on the dental chair and she likes visiting the dentist for that. I: Getting rewarded encourages participants for subsequent follow up visits.
	Feelings of discomfort and perceived pain as a reason to avoid follow-up visits	S: Participant mentions that he will visit the dentist again as he felt no pain during the treatment. A: Seems to suggest that no pain during the treatment is a contributing factor towards the experience of the participant. I: Participants tend to avoid follow-up due to feelings of pain and discomfort. S: Shares that the dentist asked her to crush something in her mouth that hurt her. She

		mentions that she may not visit again because she does not want to do that again. A: Seems to suggest that feeling of discomfort is a deciding factor for participants to avoid subsequent visits. I: Participants tend to avoid follow-up due to feelings of pain and discomfort.

Appendix I: Example of the Analytic Process (parents)

Table 4: Example of the Analytic process

Note: In this table, S-summary, A-analysis, I-interpretation

Category 1: Oral health understandings of the refugeed parents		
Themes	Sub-themes	Examples of codes
Understanding of oral health	How parents value oral health	S: Participant shared that oral health is important as one can eat and speak properly if oral health is good. A: Suggests that participant linked mouth, and its different activities like speaking and eating with oral health. I: The participant was aware of the importance of oral health. S: Says that the oral health is important for a person and if anyone experiences an oral health related problem, he/she should immediately go to a hospital and see a doctor to seek treatment. A: seems to suggest that the participant is aware of the importance of oral health and she related the problem of teeth to the hospital and the doctor.

Category 2: Barriers faced by refugeed parents before finding access to oral care for their children		
Themes	Sub-themes	Examples of codes
Barriers parents experienced prior to finding oral health care for their children	Lack of knowledge about health coverage and accessible clinics	S: participant mentions that she does not have any healthcare coverage plan as she is a refugee. A: Suggests that participant is not aware of the healthcare coverage she is entitled to in Canada. I: The participant does not possess any knowledge about the IFHP. S: Participant expresses that no one had informed her of health care services that would be available to her before or after arriving in Canada. She adds that finding a hospital or institution for accessing oral care services is a big problem when you are not aware where to go. A: Suggests that healthcare information was not available to her and that no one had informed her of it. A2: the participant considers the lack of knowledge about the institutions that refugees can visit to seek care, a problem.

	Sources of information for accessing oral care	S: Participant shares that he came to know that the refugee children are eligible for free dental treatment from his friend. His friend told him about the MCH and told him to call and book an appointment to receive treatment for his daughter. A: seems to suggest that the participant came to know about the MCH and the availability of free dental treatment for children from his friend and he was not having prior knowledge regarding accessing oral healthcare for his children. S: Participant says that she came to know about the Montreal Children's Hospital from the school teacher of her daughter. A: seems to suggest that the participant didn't know anything about the oral care institution that refugeed persons can visit to seek oral care for their children, until she was informed by the school teacher of her daughter. I: School teachers could be a potential source of information for refugeed parents, which needs to be explored further.

Category 3: Barriers and experiences of refugeed parents after finding access to oral care for their children		
Themes	Sub-themes	Examples of codes
Experiences of the parents after finding oral health care for their children	Overcoming challenges	S: Participant shares that the language is a barrier for her as she speaks a bit of English. But the hospital staff helped her by trying to understand what she was saying on the phone for appointment. She further said that she brought someone from her neighbourhood for communicating with the clinicians. A: Suggests that participant was determined to overcome language barrier and access oral care for her children. I: While demonstrating determination of parents, this quote also highlights the need of translation service at such institutions. S: Participant says that refugee dental clinics are not available in all areas where refugees live. He says that not all refugees are privileged to afford their on means of transport. He further says that it's very difficult to bring your child here on public transport when there is freezing cold outside. He suggests that having multiple refugee dental clinic is available will immensely

		help refugee population to gain access to the oral health care for their children. A: seems to suggest that the location of the MCH refugee dental clinic is a barrier for the refugee population as the refugees may not afford means of private transport. A2: The participant also expressed difficulty to bring the child to the refugee dental clinic on public transport during winter season, which might be another barrier for refugee population in gaining access to oral care for their children. I: This code highlights several barriers to care for refugeed persons such as location of the institution and transportation, and how they might be linked.
	Awaiting care	S: Participant shares that wait time before the first appointment at MCH was very long. It was more than a month wait before finally seeing the dentist A: Suggests that participant had to wait very long before finally seeing the dentist for the initial appointment of children.

	Financial challenges with dental coverage	S: Participant mentions that the staff at the MCH refugee dental clinic declined treatment for her daughter. He shares that when he came to the MCH last time, he was provided with the visiting cards of some private clinics and was told that if he can afford private treatment he must visit these clinics and seek treatment for his daughter. A: the participant expresses that the staff at MCH declined orthodontic treatment for his daughter and he was provided with the visiting cards of some private clinics and was advised to visit those clinics if he can afford the private treatment.
	Positive experiences with quality care	S: The participant says that after calling the refugee clinic at the Montreal Children's Hospital, they provide you with an appointment and the process afterwards is easy. A: seems to suggest that once the participant didn't encounter any major problem related to the oral care access for her child once she got access to the Montreal Children's Hospital.

		S: The participant says that his experience at the Montreal Children's Hospital is good as the staff is polite and take good care of his daughter. But he can't share his full experience because it's his first appointment. A: seems to suggest that the participant feels good about his experience at the Montreal Children's Hospital. I: Participant feels good but can provide more elaborate details later as this is the very first experience of the participant at the Montreal Children's Hospital.